Despite moving quickly at the outset to acknowledge the existence and threat of HIV and AIDS, Botswana has not made the progress it would have liked to curb the incidence of infection, or to stem the rise in violence against women. The authors of this book argue that this is primarily due to the inadequate involvement of men and boys in both government and non-government campaigns. Simply put, males hold the key to making a difference in stemming the tide of HIV/AIDS and gender-based violence.

Writing frankly about Botswana society, its culture and its practices of patriarchy and gender-stereotyping, as well as its sexual health and anti-gender based violence campaigns that largely target women only or are unisex in focus, the authors – academics and social activists – grapple with the question of how to make a difference. They provide evidence of what is currently happening in the country, and offer recommendations on how to alter the situation for the better – through research and policy and programmes that target boy children, men and couples – rather than focusing exclusively on women. They conclude that unless males are effectively reached, many of Botswana’s efforts will fail.

This book provides important insights into the way Batswana males and females think about HIV and AIDS and gender-based violence. Understanding the source of these attitudes can assist policy makers, development and aid organisations, health workers, educationalists, and ordinary men and women to rid the country of this dual scourge.
Male Involvement in Sexual and Reproductive Health: Prevention of Violence and HIV and AIDS in Botswana

EDITED BY Tapologo Maundeni | Bertha Osei-Hwedie | Elizabeth Mukamaambo | Peggy Ntseane
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The international community has commended Botswana for its efforts in fighting the HIV and AIDS pandemic. Most efforts have, however, largely focused on females, with minimal attention paid to males. Consequently, males have not been adequately involved in sexual and reproductive health programmes.

The aim of this book is to address this gap. It is the result of a conference that was organised by the University of Botswana’s Gender Policy and Programme Committee in November 2006. The theme of the conference was: Male Involvement in Sexual and Reproductive Health: Prevention of HIV and AIDS and gender-based violence in Botswana. The conference was part of the activities that were held to commemorate 16 days of activism against gender-based violence.

The Gender Policy and Programme Committee (GPPC) was established by the University Senate in 1991 as a standing sub-committee of the Academic Planning Committee. GPPC is responsible for:

- developing and monitoring University policy and gender issues
- promoting and supporting gender awareness and sensitivity in teaching and research
- monitoring the University’s institutional performance in relation to gender issues
- promoting staff development in the field of gender studies and research
- maintaining ties with related activities outside the University; and
- advising on the development of links with other universities and on external aid in relation to gender.

The publication of this book would not have been possible without the cooperation and support of the Friedrich Ebert Foundation (Botswana). GPPC sincerely appreciates this gesture. GPPC is also grateful to the Women’s Affairs Department (WAD) and the University of Botswana, which sponsored the conference that initiated the idea of the book. Thanks are also due to the authors of the chapters. Lastly, GPPC thanks Made Plain Communications for publishing the book.

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal clinic</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral drugs</td>
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<tr>
<td>BONELA</td>
<td>Botswana Network of Ethics, Law and HIV and AIDS</td>
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<tr>
<td>BONEPWA</td>
<td>Botswana Network of People living with HIV and AIDS</td>
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<td>CHBC</td>
<td>Community home-based care</td>
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<tr>
<td>GDI</td>
<td>Gender development index</td>
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<tr>
<td>GoB</td>
<td>Government of Botswana</td>
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<tr>
<td>GPI</td>
<td>Gender parity index</td>
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<td>GPPC</td>
<td>The Gender Policy and Programme Committee</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NACA</td>
<td>National AIDS Coordinating Agency</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>STD</td>
<td>Sexually transmitted disease</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNPFA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WAD</td>
<td>Women’s Affairs Department</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WLSA</td>
<td>Women and Law in Southern Africa</td>
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As we marshal a national effort to prevent HIV infection, assist those who are infected to live better lives and help those dying of AIDS to plan for an orderly transition, we are struck by the different roles that males and females play in these efforts.

Although men have traditionally been neglected in HIV programmes, male involvement in reproductive health is extremely important. First, males are part and parcel of activities related to reproduction. As a result, any programme aimed at addressing reproduction and health issues that targets females only is bound to fail, or to progress with difficulty. Secondly, in most societies, males are key to all reproduction decision-making at household level. Not involving them in issues of reproduction hinders the success of interventions. Thirdly, it has been suggested that there is a very fine line between gender-based violence on one hand, and sexual and reproduction health issues on the other. The alienation of males from sexual and reproductive health issues may lead them to become bitter and resort to violence as a way of venting their anger.

It was for these reasons that GPPC organised a conference on the theme: *Male Involvement In Sexual And Reproductive Health: Prevention of HIV and AIDS and gender-based violence in Botswana*. Some of the papers that were presented at the conference have been reworked into the chapters in this book.

For a long time, reproductive health issues were considered almost synonymous with family planning. The term was used to discuss issues around fertility decline, contraceptive use and teenage pregnancies. Concerns about maternal health and maternal mortality associated with fertility were also raised. These include the risks of bearing too many children; short birth intervals; early commencement of childbearing, and women over 35 years of age continuing to have children. Youth and adolescents were the main focus, especially due to their vulnerability to teenage pregnancy as well as to sexually transmitted infections (STIs).

Successes in family planning programmes were measured by the decline in levels of fertility and teenage pregnancies. In the area of HIV and AIDS, indicators involved the number of women who had heard about HIV and AIDS, and those who knew at least three ways HIV could be contracted, and at least one way of prevention. The responsibilities around reproduction lay with women. Male reproduction and their sexual reproductive health needs were completely ignored. What was known
about males was extrapolated from what was known about females. This situation of selective targeting of reproductive health programmes has not achieved the intended outcome – the reduction in the level of HIV new infections, as well as a decrease in incidents of gender-based violence.

The aims of the book
The book hopes to achieve the following:

- to encourage theoretical and empirical research and publications in gender and health in Botswana
- to increase understanding and stimulate interest among researchers, practitioners and policy makers who are concerned with gender, sexual and reproductive health as well as HIV and AIDS issues
- to share examples of best practices that effectively address gender-based violence, sexual reproductive health challenges as well as HIV and AIDS
- to explore the relationship between male non-involvement in sexual and reproductive health issues and gender-based violence in a context characterised by high rates of HIV infections
- to emphasise the need for reproductive health and HIV prevention strategies that privilege the experiences of males.

The chapters identify three core areas, namely, contextual matters; factors that contribute to gender-skewed involvement in reproductive health; and case studies that demonstrate the need for policy, HIV and AIDS education and training critical for redressing gender-based violence while enhancing positive male involvement in reproductive health. Summaries of the chapters are presented below.

Chapter 1: Inadequate Male Involvement in Health Issues: The cause of gender-skewed HIV and AIDS situations in Botswana. The chapter analyses factors contributing to men’s inadequate involvement in health programmes, emphasising cultural and biological aspects. The chapter also discusses gender-skewed participation through illustrations of community home-based care (CHBC) programmes, Prevention of Mother to Child Transmission (PMTCT) programmes and HIV and AIDS testing in Botswana. Lastly, efforts to redress inadequate male involvement are proposed.

Chapter 2: Socio-cultural Factors that Place Males at Risk of HIV Infection in Botswana: Implications for sexual and reproductive strategies. This chapter explores socio-cultural factors that place males at risk of HIV infection with implications for sexual and reproductive health strategies. The chapter argues that although patriarchal
socio-cultural practices encourage male supremacy in reproductive health decision-making, very little research has been done on male sexuality, the social construction of gender, and masculinity. In identifying the socio-cultural factors that place males at risk of HIV infection, the chapter concludes that active involvement of males in HIV research, programmes and policies could curb the rapid spread of AIDS in Botswana.

Chapter 3: Disempowerment + Blame = Zero Male Involvement in HIV and AIDS. The chapter explains the negligible male participation in sexual and reproductive health issues, with particular emphasis on HIV and AIDS. It argues that three theoretical constructs, namely disempowerment, the self-fulfilling prophecy and the blame game contribute to men’s reluctance to participate in programmes aimed at fighting the pandemic. The chapter ends by advocating for HIV and AIDS interventions that target males.

Chapter 4: Male Involvement in Prevention of Passion Killings in Botswana: Issues and challenges. The chapter discusses factors that contribute to the occurrence of femicide in Botswana and explores how men’s involvement can help in the prevention of passion killings. It highlights existing efforts to improve male involvement in the prevention of passion killings as well as challenges faced, and lastly, it makes recommendations that could curb the problem of passion killings.

Chapter 5: Couples Counselling: A tool for promoting male involvement in HIV and AIDS management in Botswana. The chapter calls for an intensified integration of couples in HIV and AIDS counselling in both government and non-government health care services, so that men can find their niche in HIV and AIDS management. It also discusses challenges to male participation in counselling and provides strategies to sustain men’s contributions to HIV and AIDS management. Recommendations to address some of the gaps identified in service delivery are provided.

Chapter 6: A Generation in Jeopardy: Sexually active women in patriarchal cultural settings and HIV and AIDS. This chapter starts off by describing the complexity of the patriarchal mentality in relation to HIV infections. For example, patriarchal cultural thinking can accord men the power to exert unfair pressure on their female partners to practise unsafe sex. The chapter argues, among other things, that giving sexually active generations assertiveness skills and self-worth can empower them to avoid risky behaviour that makes them vulnerable to HIV infection.
Chapter 7: Male Involvement in Antenatal Care and Prevention of Mother to Child Transmission Programmes in Botswana: Results of a qualitative study. The chapter explores the levels of knowledge, attitudes and perceptions of men and women towards the utilisation of antenatal care services, voluntary counselling and testing (VCT) services for HIV and the prevention strategies of HIV and AIDS, especially PMTCT. It also discusses factors that account for the reluctance of men to accompany their wives or partners to antenatal service clinics. Lastly, it highlights ways and means to enhance men’s involvement in antenatal care and promoting PMTCT programmes.

Chapter 8: Prevalence and Chronicity of Psychological Aggression among a Sample of Heterosexual University of Botswana Students. The focus of this chapter is dating violence among University of Botswana students. The chapter argues that dating relationships among students who participated in the study on which the chapter is based were characterised by physical abuse and high (90 percent) verbal aggression. The chapter concludes that psychological violence may be a serious problem among Batswana university students. In addition, males and females in dating relationships perpetrate psychological aggression at comparable rates. This highlights the importance of addressing mutually violent relationships in prevention and treatment programmes. Given the high psychological violence among students in dating relationships, prevention and treatment programmes of HIV and AIDS should address mutually violent relationships.

Chapter 9: The Voices of Sex Workers: Implications for adult education strategies. The chapter argues that sex work operates in a context defined by discrimination, violence and the risk of contracting and transmitting HIV. While acknowledging the illegal status of sex work in Botswana, the chapter argues for an appropriate legislative framework, as well as a context-and-target specific HIV and AIDS prevention strategies. Finally, the role of adult education in HIV and AIDS and policy formulation remain critical components of what can be done to achieve safer sexual behavioural change.

Chapter 10: Gender Research: The importance of data collection and analysis of male involvement in reproductive health issues. The chapter is a theoretical paper that advocates for gender-sensitive data collection and analysis. The authors argue that without proper data on the issues related to males and females, sound decision-making is impossible. To underscore the importance of gender research and gender mainstreaming, the authors highlight sector-specific gender related issues in Botswana, as well as sources of information on gender in the country.
Chapter 11: Transformation in Gender Roles and Relationships: Impact on childcare and socialisation. The chapter examines the extent to which child socialisation has been taken into the agenda for a transforming society. The idea is to stimulate readers to reflect on the extent to which men and women play their respective roles in childcare and socialisation. Attention is also focused on the reasons why females are more involved in childcare than their male counterparts. This is followed by an argument for partnership between men and women in childcare and socialisation. The last part discusses implications of the study findings for counselling, research, and policy.
Chapter 1

Inadequate male involvement in health issues:

The cause of gender-skewed HIV and AIDS situations in Botswana

Simon M Kang’ethe
Botswana remains one of the hardest hit countries by the HIV and AIDS epidemic. Despite winning international recognition as a result of campaigns and programmes, the country still faces inadequate male involvement in the HIV and AIDS arena (UNAIDS, 2001a; UNAIDS/WHO, 2005). This has had a serious bearing on the success of the programmes that the government has heavily invested in. Although the pattern and scope is changing, men have not been adequately involved in health programmes, such as PMTCT, HIV testing (see Figures 1 and 2), the use of contraceptives, and in supporting their female counterparts in tackling issues such as caregiving.

It is the realisation that men’s inadequate involvement exacerbates the spread of HIV and AIDS that has necessitated investigation of their limited participation in order to change the current status quo. As the HIV and AIDS pandemic continues to take its toll, it is imperative that both males and females should be actively mobilised to fight against it. It is therefore appropriate to examine the factors that impede men’s optimal contribution in HIV interventions.

The chapter starts with clarifying the concepts of gender and gender inequality. This is followed by an analysis of factors contributing to men’s inadequate involvement in health programmes, with an emphasis on cultural and biological aspects. Gender-skewed participation is discussed through illustrations of CHBC programmes, PMTCT and HIV and AIDS testing in Botswana. Lastly, efforts to redress inadequate male involvement are proposed.

Understanding gender

Due to a lack of understanding and clarity around sex and gender, many people take the concept of gender to be synonymous with sex. While sex refers to the biological differences between men and women, gender has to do with the roles and expectations societies have assigned men and women, and the way they have been socialised to act, behave, believe, think, and perceive. Gender, therefore, is a social construct of society. Gender roles assigned to men and women change through various social, psychological and cognitive stages of life, and stages of civilisation and modernisation (Erikson, 1968; Kimball, 1995; Wilkinson & Campbell, 1997). According to Kimball (1995), gender traits do not reside within the individual, but rather are constructed in a cultural context and through interpersonal interactions. Individuals do not have any gender, rather, they do gender (Lott, 1990; Bohan, 1993). It is assumed that if both boy
and girl children are put in the same social context and exposed to the same social forces and environments, they will behave similarly (Kahn & Yoder, 1989).

Across diverse regions of the globe, gender presents itself in a skewed dimension, unfairly determining power dynamics, resources and decision-making capacity between men and women, with men receiving the lion’s share. This has, therefore, facilitated biased or lopsided development, which affects how men and women can acquire opportunities, how they are distributed, and their availability in all areas of socio-cultural, economic and political life. This is evidenced in many countries’ gender parity index (GPI) reflecting the number of boys enrolled in schools compared to girls; the number of working men relative to women, and generally the pay difference between men’s occupations compared to women’s. Research shows that by and large, men tend to be paid relatively higher wages than women (UNDP, 1995). In many developing countries, women are concentrated in jobs and economic activities that bring low earnings, are irregular and insecure, and are beyond the effective reach of labour and social protection laws: ‘In no society today do women enjoy the same opportunities as men’ (ibid: 29). This is due to gender inequality and inequity and explains how women’s vulnerability leads them to poverty.

Poverty coupled with gender-based violence by men has made the life of women, especially in the developing world, a sad state of affairs. This has made it difficult for females to negotiate safer sexual practices, thereby exposing women to the virus. This could explain why, across the globe, more women than men are infected with the virus (UNAIDS/WHO, 2005).

Women have borne the brunt of gender-based violence. Research by the United Nations on gender-based violence in Botswana indicates that four women are reported raped each day, while more than half of all deaths of women are committed by their intimate partners. However, deaths of women at the hands of other close family members, and to some extent strangers, are not uncommon (UNDP, 2008). The depth and magnitude of gender inequality and inequity, coupled with traditionalism, custom and belief systems, especially in Africa, make the road to gender equality and equity appear rough.

The United Nations’ General Assembly defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (UN, 1993). Gender-based violence, therefore, is the violence that is meted to the weaker of the two genders by the stronger gender. Partriarchy allows men to intimidate and brutalise women with impunity. While perpetrators of gender-based violence could either be male or female, studies across the globe have shown that women make up the majority of the victims (UNDP, 2008). The few cases of women abusing men
constitute a drop in the ocean, and may in fact, represent women responding to a history of the man’s use of violence against them (Dobash & Dobash, 1998). Political and traditional leadership may also contribute to creating an environment in which cases of violence are not given the seriousness they deserve. If, for instance, these systems do not see the need to give both genders equal rights, and ensure redress, then the power dimensions could dictate power equations to oppress the weaker gender. This supports the findings in a 2001 national workshop on gender-based violence in Botswana by the Women’s Affairs Department (WAD), that power relationships which underlie gender-based violence are based on socially, culturally and politically constructed differences between the sexes (WAD, 2001).

Though violence has many dimensions, the actual extent of gender-based violence in Botswana is still largely unknown, as very little research has been carried out in the area. However, there is evidence on the ground for the following kinds of violence:

- physical violence
- sexual violence that includes rape, marital rape, the sexual exploitation of girl children, incest and sexual harassment
- psychological or emotional violence, and
- economic violence that includes property grabbing and the failure to maintain children (WAD, 1999, 2001).

Studies indicate that the majority of gender violence cases against women and girl children occur in the home and are instigated by males within the family, including husbands, intimate partners, fathers, uncles, brothers or cousins. Regrettably, such cases are settled within the family settings and are only revealed when serious damage occurs such as physical injuries, pregnancy or death (Mogwe, 1988; GOB-UNICEF, 1989; WAD, 1999; WILSA, 1998).

Physical violence usually involves men using their hands, a belt, a whip, a knife or other objects. A national study conducted by the Women’s Affairs Department in 1999 showed that in 60.4 percent of the households surveyed, women had been subjected to gender-based violence at the hands of their husbands or intimate partners, with battering being the most common. Women do not or are not ready to report the violence unless it becomes unbearable or causes serious injuries. This is because they fear the loss of economic support from men (WAD, 1999; UNDP, 2008).

Sexual violence in Botswana is manifested in rape, marital rape, sexual assault, sexual harassment, sexual abuse of minors (children under 18 years) and incest. It is worth noting that rape cases are increasing. Botswana police statistics indicate that in 1995 there were 1,056 rape cases, while 2007 saw 1,596 registered cases, an increase of over 50 percent. Passion killing or femicide is the climax of physical gender-based violence. The following statistics bear evidence of the increased magnitude of gender-
based violence (see Table 1). In all cases of violence, the risk of women becoming prey to viral transmission is very high.

Table 1: Reported Cases of Physical Violence Against Women by Men: 2004-2007

<table>
<thead>
<tr>
<th>Type of Physical Violence</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault: Common</td>
<td>10,855</td>
<td>11,803</td>
<td>11,081</td>
<td>11,899</td>
</tr>
<tr>
<td>Assault: Occasioning Bodily Harm</td>
<td>6,186</td>
<td>5,870</td>
<td>5,343</td>
<td>6,018</td>
</tr>
<tr>
<td>Passion Killing</td>
<td>56</td>
<td>85</td>
<td>62</td>
<td>101</td>
</tr>
</tbody>
</table>


The feminisation of poverty is the tragic consequence of women’s unequal access to economic activities. This state of female gender deprivation and destitution adversely affects the country’s development overall, contributing to many countries’ vulnerability and being stigmatised as ‘Highly Indebted Poor Countries’ or ‘Less Developed Countries’. The narrowing of the gender gap is a valid and relevant indicator of the standard of living a country enjoys, and is a significant factor in the global computation and ranking of standards of living. NORDIC countries (Finland, Norway, Denmark and Sweden) remain enviable examples of gender development. Developing countries that want to march along the gender road to equal opportunity development status need to work hard to narrow this gap. Consequently, the WAD in the Ministry of Labour and Home Affairs in Botswana is leading robust campaigns and advocacy strategies to convince men and women of the need to allow easier permeation of the rights of women in all areas of life in order to achieve equal gender status. Unequal power gender differentials are considered to be an abuse of human rights. Gender disparities in Botswana have been identified as responsible for the increased poverty of women and for gender-based violence. Other factors have also contributed, such as gender-based biases towards property rights.

Within the developing world, Botswana has a relatively higher gender development index (GDI). This is evidenced by, among other things, the fact that boys and girls get the same opportunity to access school. The United Nations’ 2003/2004 Education For All monitoring report singles out Botswana and Namibia for having achieved a GPI score of one. However, gender development is still not strong and continues to derail the implementation of HIV and AIDS campaigns. The Education For All report also identified tradition, poverty, religion and armed conflict as major causes of imbalances in educational access between boys and girls in many countries of the developing world (Botswana Daily News, 2004).
Inadequate male involvement in HIV/AIDS programmes in Botswana

In the developing world especially, HIV and AIDS has challenged resources to the extent that concerted efforts by all stakeholders are needed to produce a formidable response. The contribution of both male and female genders needs to be enlisted for a healthy and balanced response (UNDP, 1995). The principle of ‘shared rights and shared responsibilities’ espoused in the 1995 World Health Organization’s AIDS Day theme implicitly calls for both genders to actively participate and reinforce one another to beat the epidemic (NACA 30, 1996). Many countries, Botswana included, committed to relentlessly fight against HIV and AIDS to halt the spread of the epidemic as part of the 2001 United Nations Declarations, which were espoused in the United Nations General Assembly Special Sessions (UNGASS), and also formed the global AIDS Day theme for 2005 and 2006 – ‘keep the promise’ (UNAIDS, 2001a).

The phenomenon of inadequate male involvement in addressing health challenges is prevalent in many regional settings of the world (Patton, 1994; Jackson, 2002). Gender inequality and inequity, and biological factors play crucial roles in that male to female viral transmission is far more efficient than the converse, or female–male transmission (Patton, 1994:10). Men, therefore, have more opportunities to contract and transmit HIV; they usually determine the circumstances of sexual intercourse, that is when it takes place, and the environment in which to do it, which method to use, and whether to use protective contraceptives or not. Men bear the major part of the blame and responsibility for refusing to protect themselves and their partners. The message espoused in the year 2000 World Health Organization AIDS Day that ‘men can make a difference’ underlies and underscores the need for men to change, and to be responsible for turning the tables on the epidemic. However, this calls for a paradigm shift in men’s attitudes, norms and cultural belief systems. Much campaigning and advocacy directed at men is necessary (UNAIDS, 2000a).

The HIV and AIDS campaign in Botswana has been gender biased in the sense that male involvement has not been adequately sought compared to women’s. This has been a programmatic oversight and mistake in the campaign programme conceptualisation, operationalisation and implementation. Men have also not taken the message and challenge of their involvement seriously. This is despite the passionate appeal by former President Festus Mogae and other HIV and AIDS proponents in the year 2000 on AIDS Day that they change their stand and be more conspicuous especially in matters pertaining to their health and HIV and AIDS campaigns generally (UNAIDS, 2000a). In short, men’s involvement has not been satisfactory in many programmes.

The Kanye village structures give credence to this (DMSAC report, 2003, 2004). In 2005, research by Kang’ethe (2006) on the caregivers in the Kanye CHBC programme
showed that only two out of approximately 140 registered caregivers were men. The lack of support of men in these programmes has had the effect of undermining and compromising the national HIV and AIDS campaign, in which government has heavily invested as a means of complementing and decongesting the health institutions and facilities (NACP 30, 31, 1996).

The reasons for the initial focus on women in government campaigns are numerous. Firstly, the HIV and AIDS phenomenon took many countries off guard and unprepared, so limiting a measured response. Secondly, the fact that more women than men appear in different contexts to be infected and affected also skewed the response structure towards women. The campaign also concentrated on women because of the desire to save newborn babies, whose lives would be compromised if born with the virus (MoH, 2005). Concentrating on women could also have emanated from the fact that the first sentinel surveys were carried out using sero-positive statuses of women attending antenatal clinics, and not men. Though later national sentinel surveys included sero-positivity of men who attended the clinics, men were not very conspicuous in the survey. Therefore, campaign and advocacy has accumulated many years dealing almost solely with women. The gap was only realised when it was too late. Inadequate male involvement, therefore, can be seen as a structural gap created by the country’s own campaign mechanisms.

**Factors contributing to men’s inadequate involvement in health issues in Botswana**

Inadequate male involvement is attributable to an array of factors, including culture, patriarchy and biological make up. In many cultures, the thinking that ‘a real man is not satisfied by one woman’ encourages male promiscuity and male dominance. This is shown in Setswana proverbs such as *monna ga a ago a gela lela* that loosely translates as ‘a man should not be tied to one woman’; *monna ke selepe, o a hapaanetwa, monna ke selepe, o a ta tsay o a rema*, which translates to the idea that a man has the freedom to associate with multiple and concurrent partners. In many cultures, ideals of manhood include strength, courage, dominance, and unfettered sex. Men, for instance, are believed to be strong and able to endure disease. This thinking is well grounded and internalised in many men’s and women’s minds from childhood, and has continued to linger and influence men’s responses to disease (Jackson, 2002).

Culture represents societal values, norms and practices that are passed down the generations. Culture has always been a mirror of society, representing the society’s thinking, its cherished values, its do’s and don’ts, and sets the pace for change in any society. In most societies, it is culture that dictates how power is to be shared between men, women and children, and the treatment and value of boys relative to girls, with
the same kind of thinking about the supremacy of men over women continuing in later life (Kimball, 1995). The values emanating from patriarchy and masculinity have been borrowed and deeply ingrained in cultural customs and traditions dictating the borders of particular gender roles and differentiation. Usually household related chores, issues of house hospitality and taking care of the sick have been culturally and socially assigned to the female gender. This is the status quo even today. However, the advent of HIV and AIDS, modernisation and eurocentricism demands a departure from this kind of practice, calling for gender swaps, gender realignment and dismantling of gender stereotypes that relegate a particular task to a particular gender (Kutloano, 2001, Kang’ethe, 2006). Campaigns supporting gender swaps, gender liberalisation and freedom, which allow boys and girls to take any role or pursue any course in school – even those that have traditionally been the preserve of a particular gender – should be encouraged. This will no doubt bring in a new paradigm that allows men to take caregiving roles with ease.

Patriarchy has been identified as one of the contributing factors to men’s inadequate involvement in health issues. This is because women have not been well placed to adequately persuade men to participate with them in health matters. The reason for this is the decision-making power that men wield over women because of patriarchal power dynamics. Patriarchy refers to power attained by men through culture and custom over time and generations. Men have used this power to oppress women in many ways, socially and economically. The Holy Bible also strengthens patriarchy. Some people believe that patriarchy finds its roots or is borrowed from biblical principles. This is because it refers to the power of fathers over children and women (MacArthur, 1997). The Christian perspective has therefore reinforced patriarchal powers: women are taken to be the ‘neck’, while men are the ‘head’. According to biblical based patriarchy, women are supposed to be controlled and follow the whims of men. It is believed that the power of men is ordained by God and cannot change. ‘Wives, submit to your husbands as to the Lord. For a husband has authority over his wife, just as Christ has authority over the Church…’ (MacArthur, 1997:1813).

These patriarchal beliefs have been responsible for bestowing socio-economic and political powers on men to control women and children, creating gender inequality and inequity. It has influenced men to shun sharing and responding to responsibilities such as, for instance, caregiving. Women have been left to toil alone (UNDP, 1995).

Although there are differences in how patriarchy is seen, all thinking gravitates towards men controlling their women counterparts. Marxian thinking, like that of Friedrich Engels, sees patriarchy as having roots in the development of the concept of private property – of animals, tools and land – and in man’s attempt to control more of the surplus (Kahn & Llobera, 1981; Gray, 2000). Men established their dominance
within the household, while society and patrilineal lines of inheritance reduced women to servitude and the instruments of child bearing. This idea of patriarchal powers has unleashed gender-based violence against women (Mookodi, 2004). More than half of all murders of women in Bangladesh, Brazil, Kenya, Papua Guinea and Thailand are committed by present or former partners (UNDP, 1995).

Traditionally, women have taken care of the sick at home. This is now deeply rooted socially and culturally. Kelesetse (1998), Finch (1984) and Walker (1982), all feminist proponents, contend that caregiving in CHBC by women is a societal exploitation of the female gender. Their perspective may be supported by the United Nations view that suppressive and exploitative labour imposed on women without appropriate remuneration and legal protection is an abuse of human rights (UNDP, 1995). Gender mainstreaming and gender analysis geared towards balancing gender power should be encouraged by all social institutions.

Education about gender issues could be pivotal in changing the situation of gender in any forum. Societies need to be educated to change traditions, customs and cultural stereotypes dictating, for instance, that caregiving should be a female gender responsibility alone. Education would encourage societies to undergo the process of gender swap (Kutloano, 2001:3) so that families and communities can share caregiving. This is a process of engendering or striving for gender balance, which is very healthy for social, cultural and economic development (UNDP, 1995). Gender mainstreaming campaigns to obliterate aspects of gender inequalities and facilitate gender transformation, therefore, need to be infiltrated in all social institutions, including caregiving institutions, if these power inequalities and inequities are to change.

**Biological factors influencing men’s involvement in health issues**

Biological factors also play a role in the inadequate involvement of men in health issues. Biological factors have favoured men in bestowing them with a physique that enables them to take on harder manual tasks, while women take lighter and more menial tasks (Kimball, 1995). Since caregiving is a relatively lighter and more domesticated task, it has socially and culturally fallen into the hands of women. This has made it difficult for men to accept and respond to the call of helping in caregiving tasks.

Although biological differences are acknowledged, their meanings are also socially constructed (ibid). However, since HIV and AIDS has challenged all institutions, calling for additional reinforcements, especially in human resources, these biological values coupled with culture and tradition need to be challenged. Education about gender and the process of engendering needs to be expedited, especially in all institutions of
learning, and should start with children at the early stages of their development. It is the only way to dismantle the stereotypes emanating from biological values of masculinity.

Gender-skewed participation in health care programmes

To appreciate the gender-skewed nature of health care programmes and inadequate male involvement in the HIV and AIDS campaign, it is important to point out the evidence of inadequate male participation in the campaign. Several health programmes show men’s minimal involvement in HIV activities, some of which are outlined below. Illuminating these programmes and bringing out the challenges is an opportunity for all, including the government and those responsible for programmes and communities in general, to accept the need to mobilise men and change the environment that impedes their full involvement. These programmes include CHBC, PMTCT and HIV testing.

CHBC programmes

CHBC is a valued and a well-grounded concept, deeply embedded and inherent in the societal values of most communities in Africa. It has been common practice for generations. Researchers in the field, like Pierre Broud, have commented that among Africans, there is a strong sense of community and a rich tradition of doing good work, of reaching out to one’s neighbour or sick friend especially in times of sorrow and distress (Mensah, 1994; Broud in UNAIDS, 2000b). The concept of CHBC includes any form of assistance to a sick person (referred to as a patient or client) in their home, with family members, friends and members of the local community, supported by skilled health care workers, providing this care (Muchiru & Florich, 1999). The care given may be palliative or rehabilitative, physical, psychosocial, spiritual, and may involve material support. Caring, especially for persons living with AIDS, is an overwhelming exercise, as most caregivers have no hope of their patients recovering. Most caregivers are forced to take death as part of life and dying as simply ‘living to the end of life’ (Sims & Moss, 1991). To support patients with AIDS ‘living to the end of their life’ as is common practice in CHBC programmes, requires caregivers with strength and an awareness of the unique needs of individuals nearing that end. This includes the need to be safe and not to be hurt, to be given refuge or sanctuary, and to be comforted, and the need to be accepted and to receive love (ibid; Uys & Cameron, 2003).

Emphasising the importance of community care and the need for the help system to be bolstered, McDonnell et al (1994:429) remark that ‘This source of support must not be taken for granted. As the number of ill persons increases, communities may become overwhelmed and, lacking support, abandon their traditional caring roles’.
They point out that this would be devastating, especially in developing countries where formal caring systems are either inadequate or not affordable. Dendere in UNAIDS (1999:83), says that ‘family is the most important resource for our clients… and that home care cannot be neglected’. This implies that home care must be supported because it meets patients’ needs effectively, and not because it reduces demand on the local hospital beds.

The situation of caregiving in Botswana, supported by empirical data, suggests that it suffers great gender bias, and, therefore, experiences an inadequate engendering process. Caregiving is predominantly run and managed by women (Mojapelo et al, 2001; Kang’ethe, 2004, 2006). Empirical findings in Kanye by Kang’ethe (2006) indicated that 98 percent of the caregivers are women. Other similar studies indicate the same trend. In a study by Khan & Stegling (2000) in Kweneng, all 28 caregivers were women, while in another study, still in Kweneng by Mojapelo et al (2001), 89 percent of the caregivers were women. Atta & Fidzani (1996), in their study on caregiving indicated that over 50 percent of caregivers in most of the Botswana CHBC programmes are elderly women who may not be able to follow the hygiene protocol in the care process. Munodawafa’s study (MoH/NACP 41, 1998) on caregiving had all but one male caregiver in Tutume, while in Molepolo, all caregivers were females.

**Girl children as caregivers**

An increasing phenomenon is the emergence of girl children as caregivers, partly because men are not ready to take on caring tasks. Caregiving by children is a desperate move and an indication of inadequate care delivery from both the provider and recipient perspective. Worse, the care programmes do not have any preparation process in place, and these children have to struggle on, either to float or sink (Mojapelo et al, 2001; Kang’ethe, 2006). Studies by Tlou (1999) and Mathebula (2000) also support the findings that in Botswana, elderly women and girl children are the major caregivers to people living with AIDS, yet these caregivers have few resources such as good nutrition, transport and professional support. Girls are usually forced to leave school after their parents succumb to AIDS or are too weak to take care of the rest of the siblings, even if bigger boy children in the family may be free and not attending school. Some girl children are forced to head households (UNAIDS, 2000b, 2001b; Kang’ethe, 2006). This has had the impact of compromising and devastating the future of girls as they are forced to drop out of school. But care tasks performed by the girl child result from socialisation of the female gender that dictate that caregiving is a female gender role. According to the United Nations Conventions on the Rights of Children, involving the girl child in caregiving assignments, especially at a tender age, constitutes a breach of article 15 on child labour, which states that every child shall be protected from all forms of economic exploitation.
and from performing any work that is likely to be hazardous or to interfere with the child’s physical, mental, spiritual, or social development. Caregiving responsibilities forced on children are stressors that hinder their psychological, physiological and social development (OAU, 1990; Nyati-Ramahobo, 1992).

With approximately 256,000 persons living with HIV and AIDS in Botswana (NACA, 2005), the chances of children taking up adult roles may become common. However, access to antiretroviral drugs (ARVs) and its successful acceptance by the clients (those who observe the medical and treatment protocol), is likely to assist ill parents to regain their strength. Once parents are strong, they might relieve and release the girl child back to school. Botswana’s fulfilment of the World Health Organization’s (WHO) ‘Three by Five’ target indicated by the country availing its globally allotted share of people living with HIV and AIDS (55,000) with free ARVs, provides hope that many HIV and AIDS patients could return to healthier situations (UNAIDS/WHO, 2005).

The PMTCT programme
HIV infection in children threatens to reverse the progress Botswana has made through wide-scale implementation of child survival programmes such as immunisation, improved management of childhood illnesses and breastfeeding promotion (MoH, 2005). Research indicates that approximately 50 percent of HIV positive babies become infected at the time of labour and delivery. This means that children born positive under normal circumstances would not survive their fifth birthday (MoH, 2005). It is estimated that without action to interrupt mother to child transmission of HIV, the under five child mortality rates will more than double in Botswana, Kenya and Zimbabwe by the year 2010. This, therefore, poses a danger to the future of the country, with its small population of 1.8 million (Gaolathe, 2008:11). Such a phenomenon could lead the country to near extinction if left unchecked.

Since the inception of the programme, socio-cultural forces have militated against its success. For the PMTCT programme to succeed, a mother needs to know her status and then enrol in the programme. However, many mothers cannot enrol due to lack of permission or encouragement from their male partners. Therefore, the programme has suffered an uphill task as mothers and families fail to respond to persuasion and campaigns to enrol. Stigma and culture have also played a pivotal role in derailing the success of the programme. As men appear to be affected more than women by stigma, they have to an extent not encouraged their female counterparts to be tested, or enrol in the programme. The PMTCT programme has, therefore, suffered setbacks because eligible beneficiaries refuse to test or prefer to keep their status secret for fear of stigmatisation, discrimination and even physical abuse (Kalanke, 2004). The PMTCT
beneficiaries are also scared to be identified with large quantities of ‘formula milk’ (used by HIV positive women to avoid breastfeeding) as people would conclude they are HIV positive (Baggeley, 2000).

Issues of childbearing revolve around the advice of the elderly members of society. Some grandmothers and parents have, for instance, not accepted seeing their granddaughters or daughters failing to breastfeed their newly born children. Therefore, this programme has not been able to register a very high rate of success.

**HIV testing**

Testing, across regions and continents, has a cardinal role in reinforcing positive behavioural change processes. The success of beating the epidemic all over the world depends on the magnitude of behavioural change. However, to help those infected, it is important for communities and societies to know their status in time to allow fast and effective intervention (*Mosele wa pula o epiwa go sale gale*). This is central and urgent in Botswana where the government provides free ARVs. Even if the government had met the ‘WHO Three by Five’ initiative of accessing at least 55,000 of its clients living with HIV and AIDS with ARVs by end of 2005 (UNAIDS, 2001a; UNAIDS/WHO, 2005), this is not good enough considering that the country has 256,000 persons living with the virus, based on the Botswana AIDS Impact Survey (BAIS 11) indicating a national HIV and AIDS prevalence of 17.1 percent (CSO, 2004).

Though, generally, the people of Botswana should be commended for their continued response to testing, the number of men coming for testing is still lower than that of their female counterparts (see Figure 1) (NACA, 2006; Tebelopele, 2005–2007). Further, Tebelopele data indicates an even bigger decrease in second-time testers for both men and women, leaving a big question mark around the repercussions for this section of people, who, after knowing their status for the first time, fail to honour the testing expectations of continued testing. It is my suggestion that we interrogate our counselling services that accompany the testing sessions. It could have gaps or not adequately be equipping clients with enough impetus to desire positive living and, therefore, wish to continue monitoring their viral history.

Continued testing, however, is the only sure way of ensuring that one continues to be negative or if positive, permits monitoring of the level of viral load in the body. This is important as it facilitates knowledge of the entry point of ARV intervention. It is also very dangerous, if after knowing one’s status, there is no further commitment to behavioural change. The government of Botswana has prioritised and diverted large resources to fighting the scourge, and all its people, locals and foreigners, should increase their level of commitment to support the efforts and constant passionate calls for strengthened stakeholder partnership and behavioural change (Kang’ethe, 2007).
Men’s response to testing is worrying because women’s response to testing may be stifled if their male counterparts do not support them. This is a gap that needs to be closed once and for all. This is why Kang’ethe (2007) calls for a campaign dynamic that attracts and encourages couple testing. Leaders of all calibres, from central to grassroots level should change their campaign approach to ensure that everyone goes for testing in pairs, whether they are married couples, boyfriends and girlfriends, or cohabiting. This would help take testing to another level likely to change the magnitude of the ravaging epidemic. It would also be a sure way of approaching the envisaged zero viral transmission or an AIDS free generation at the dawn of Botswana’s 50 years of independence (Republic of Botswana, 1997; NACA, 2005).

**Efforts to redress inadequate male involvement in the campaign**

The national HIV and AIDS campaign in Botswana has inadequately involved men. This could be due to poor vision and poor understanding of the gender dynamics and the challenges they pose to the HIV and AIDS campaign. Again, the methodology and approaches that have traditionally been used, like testing only pregnant women and a few men with sexually transmitted infections at health facilities made AIDS appear more of a women’s problem, rather than one of both men and women. This was also ignorantly reinforced by many cultures seeing women as responsible for transmitting the virus. For the most part, campaign policy frameworks and programme interventions have been directed at females’ sexual reproductive health and HIV and AIDS, and, therefore, more is known about females and HIV than about males and HIV. The inclusion of males in the campaign and correcting the HIV and AIDS policy and programme intervention gaps to fully embrace men has developed at a snail’s pace (Mookodi & Maundeni, 2006).

It was only after government realised that overly targeting women was to the detriment of both men and women, that it started placing special emphasis on men’s response to the epidemic. This saw the birth of the Men’s Sector, targeting the defence force, police service, immigration and prison’s department (National Strategic Framework, 2003–2009). In this sector, it is men who are reaching out to other men by emphasising behavioural change. The goal of the Men’s Sector is to encourage men to contribute more and take greater ownership, and to persuade men to use their political, economic and socio-cultural might to change the landscape of the epidemic. Education, especially, around modes of transmission and the position of man in transmission underscores the mandate of the Men’s Sector. This is because men’s viral transmission is more effective and efficient than women, due to biological factors and socio-economic and cultural circumstances surrounding men in society (Patton, 1994).
The efforts of the Men’s Sector need to be appreciated and supported. Their efforts are in line with the World Health Organization’s year 2000 AIDS day theme ‘Men can make a difference’. This has challenged men to step up their response. The Men’s Sector has enjoyed much government goodwill and resources. With patronage revolving among the four initiative departments of police, immigrations, prisons and the army, the Men’s Sector has been going all over the country to sell its gospel of more commitment by men in the HIV and AIDS campaign. It has taken advantage of all the available forums, such as the District Multisectoral AIDS Committees, to mainstream, mobilise and drum up support. This has culminated in forming Men’s Sector committees at district and other levels in society.

Though no impact needs assessment has been done on its performance, the men’s sector, gauged by what is apparent on the ground, has marketed itself well. The main message and challenge the Men’s Sector is contending with is to dismantle the underlying factors (culture, stereotypical thinking, and behaviours) which make men responsible for fuelling the epidemic, such as multiple partnering and failure to respect the use of contraceptives (NSF, 2003–2009; NACA, 2005).

**Conclusion and recommendations**

Men must be positioned at the centre of HIV and AIDS campaigns if meaningful gender neutral dividends are to be realised. The result of a gender-skewed campaign is caused by the omission of men by the campaign architects. Policy frameworks need to adjust to allow men to move in tandem with their female counterparts. However, besides inadequate involvement in the campaign, cultures reinforced by patriarchal forces and beliefs have bestowed man with the power of dominance, and oppression of the female gender. This is to the detriment of the campaign against HIV and AIDS and women empowerment.

With socialisation dictating the place of each gender in society, males have had a lot of power and have dictated their relations with females. Gender-based violence meted out against women has been one of the results of this power dynamic equation. In caregiving, men have not been keen to help their female counterparts in taking care of the sick despite the state of affairs prompted by the epidemic. The call for societies to work towards dismantling cultural and partriachal forces and cultural beliefs and socialisation that compromise a healthy gender development, is timely. A strengthened campaign around gender, especially targeting the young from childhood, is a sure way of effecting the desired gender balance in future societies. The mistake of leaving the boy child out of discourses around gender development should not be repeated. Gender mainstreaming education in schools from an early age would help change the societal mindset.
Gender skewedness has negatively influenced the degree of success in important government programmes such as PMTCT. Considerable lobbying and advocacy using all possible public forums, print and electronic media, should be enlisted to work to change this state of affairs. Men have also lagged behind women in the testing campaign. There is a false perception among many Batswana that they are not able to take advantage of free antiretrovirals and other government assistance packages. This is directly affecting the campaign and frustrating government efforts to help its citizenry. Increased testing has been found to contribute to identifying those who need treatment. It is therefore central that community awareness and testing campaigns targeting all segments of society be intensified. It is also recommended that concerted efforts be made to change the traditions, norms, cultures and mindsets dictating that one gender should benefit to the detriment of the other (Kang’ethe, 2006). A transformation towards gender equality and equity is the engendering process. This would be a healthy situation, as many of the global problems and challenges are the product of unequal power differentials, with males oppressing females to the extent of suffocating social, cultural, political and economic development.

However, it is not fair to continue blaming men as mere vectors of viral transmission without acknowledging that the campaign structures have not adequately targeted them in the fight against HIV and AIDS. Research in the area of male involvement and sexuality to inform interventions is long overdue. This gap needs to be closed, policy and operation wise. Government, civil society organisations and NGOs dealing with the HIV and AIDS campaign should boldly face factors that contribute to inadequate male involvement, and gender-based violence. An understanding of these factors would inform visionary, sound and meaningful interventions. Serious and spirited campaigns sensitising all organs of society to the dehumanising aspects of gender-based violence could prompt society to want to tackle the gender imbalances that create a conducive environment for gender-based violence to thrive. Organisations driving campaigns against gender-based violence such as Emang Basadi, BONELA, Ditswanelo, and the Women’s Affairs Department should attract government and international funding so that they can scale up their operations.
Figure 1: PMTCT Uptake (January 2004 – June 2007)

![Graph showing PMTCT uptake]

- New ANC Clients: 11124, 10304, 10598, 11622, 13800, 12501, 11947, 13247, 10418, 11883, 11560, 11765, 8287
- Number Tested: 7932, 7669, 8696, 9814, 11508, 10686, 10487, 9892, 10688, 8844, 10183, 9527, 9400, 6835
- Number Positive at ANC: 2251, 2363, 2778, 2885, 3372, 3314, 3294, 3025, 3297, 2687, 3196, 2857, 2728, 1921

Figure 2: Tebelopele HIV Prevalence By Sex (January 2005 – June 2007)

![Graph showing HIV prevalence by sex]

- Males: 30.1, 26.5, 23.8, 21.7, 21.6, 19.7, 19.8, 17.5, 18.9, 16.4

INADEQUATE MALE INVOLVEMENT IN HEALTH ISSUES:
THE CAUSE OF GENDER SKewed HIV AND AIDS SITUATIONS IN BOTSWANA
Male Involvement in Sexual and Reproductive Health: Prevention of Violence and HIV and AIDS in Botswana

References


HIV prevalence showing decline. 2006. *Botswana Guardian*, 1 December.


Lott, B. 1990. Dual natures or learned behaviour: the challenge to feminist psychology.


Ministry of Health (MoH)/NACP 41. 1998. Evaluation of the CHBC pilot project (Molepolole & Tutume sub district.) Gaborone: Republic of Botswana.


Chapter 2

Socio-Cultural Factors that Place Males at Risk of HIV Infection in Botswana:

Implications for sexual and reproductive health strategies

Tapologo Maundeni and Godisang Bridget Mookodi
Botswana’s high HIV and AIDS prevalence rate shows that prevention interventions have not resulted in behavioural change. Most research and interventions on gender and HIV and AIDS in Botswana have focused on females (cf Hope, 1999; Stegling, 2000; UNDP, 2000), while little is known about males. HIV and AIDS are gender issues; they cannot be adequately addressed if research and interventions are one-sided. It is therefore crucial that research and interventions on males are intensified. The scanty literature on males and HIV and AIDS has emphasised that in order for HIV strategies to have a greater impact, there needs to be both research and programmes that target males (cf Maundeni, 2004; Fuh, 2004). Research is important since it shapes programmes. This chapter is based on the findings of a study that was funded by the Organisation for Social Science Research in Southern and Eastern Africa (OSSREA). The study was called: ‘Gender and HIV and AIDS: Male Risk and Male Sector Interventions in Botswana’.

The objectives of the study were aimed at:
- assessing the socio-cultural factors that determine male risk behaviour, or place them at risk of infection
- examining the approaches and methods utilised by the various stakeholders in their work on male-focused HIV prevention
- assessing the impact of the interventions with target groups, and
- identifying the successes and challenges faced by male sector interventions in Botswana.

This chapter focuses only on the first objective: it analyses socio-cultural factors that influence male risk behaviour or places them at risk of HIV infection. Towards this end, it reviews the literature on the socio-cultural factors that contribute to male’s risky behaviour, and the methodology followed. This is followed by a presentation of the findings of a field study. Lastly is an examination of the implications for sexual and reproductive health strategies.

The socio-cultural context
For the purpose of this chapter, culture refers to the way of life of people. It consists of patterns of thought and behaviour, including values, beliefs, expectations and rules of conduct that are passed from one generation to another (Kuper & Kuper, 1985). Male gender identities and sexuality are shaped and altered throughout the life course. While macro-societal factors play a significant role in shaping masculinities and male
sexual behaviour, the individuals are not relative ‘sponges’ – soaking up these messages without processing them through individual agency. Connell states that:

They are not just passively engaged in role learning and being ‘socialised’. At the same time their activity is social practice, drawing its meaning from a social framework (language, material resources, social structure), and having effects in the lives of others (2005:13).

Much of the research on females and HIV and AIDS in Sub-Saharan Africa and Botswana has pointed to the significance of socio-cultural beliefs and practices that place females at risk of HIV and AIDS. Findings of such studies point out that culturally based patriarchal practices encourage and perpetuate male dominance over women and contribute to the rapid spread of HIV. Gender imbalances in most African societies are manifested in women’s limited access to and control over political power and economic resources in comparison to their male counterparts (Women In Development in Southern Africa Awareness, 1998; Mvududu & McFadden, 2001). In addition, many socio-cultural beliefs that are embedded in socialisation and sexual relationships within and outside marriage tend to increase females’ vulnerability to infection (Maundeni, 2002). Women and girls often become victims of men’s risky sexual behaviour which includes the latter’s reluctance to use condoms in sexual intercourse; their tendency to have multiple partners, as well as their perpetration of violent acts such as rape (UNDP, 2000).

What emerges from the literature is that patriarchal socio-cultural practices that encourage male supremacy result in males ultimately being held responsible for the escalating HIV and AIDS prevalence in Botswana (Fuh, 2004). Doehlie and Maswabi (1998) and Mookodi (2004) hold that while men are often assumed to be responsible for the dramatic spread of HIV and AIDS in Botswana, very little has been done to research male sexuality. Minimal efforts have been made to understand the contexts in which males express their sexuality and how their sexuality is constructed within a social context. This chapter helps to fill such a gap through the research undertaken in three areas of Botswana as discussed below.

**Research findings on the socio-cultural factors that place males at risk of HIV infection**

The study was conducted in Gaborone, the capital city of Botswana; Kasane, a town in the north of Botswana, and in Maunatlala, a village in the central district of Botswana. The rationale for choosing Gaborone was the fact that most male sector interventions were based there. Kasane and Maunatlala were chosen for comparative purposes.
While the Men Sex and AIDS organisation has been operating in Gaborone and Kasane, there were no known male sector interventions in Maunatlala.

The study adopted the qualitative research paradigm as the appropriate approach to effectively explore issues of sexuality and HIV and AIDS, which are often obscured by quantitative survey methods. Qualitative methods are participatory in nature and seek to understand the participants’ realities. The study employed four data collection methods: 12 key informant interviews, ten focus group discussions, 60 individual interviews with males between the ages of 15 and 50 years, and a stakeholder workshop. These methods were complementary as they yielded information that addresses the objectives of the research. The data for this study was collected in collaboration with the Men, Sex and AIDS organisation. The organisation had trained peer educators in Gaborone, Kasane, Selibe-Phikwe and Gantsi. The peer educators assisted the principal researchers to collect data in all of the research sites.

The study found that the following factors place males at risk of HIV infection:

- males’ tendency to learn about sexuality issues largely from peers and the media
- boys’ relationships with older women
- the relative absence of community and family-based male socialisation agents
- inadequate knowledge about HIV and AIDS; and
- males’ views about vulnerability, as well as their views about love relationships with females.

These are explained in some detail below.

**Males’ tendency to learn about sexuality issues largely from peers and the media**

The results from all three study areas indicated that males learn about sex from a very tender age. Most of the adult respondents learned about sex from *mantlwane*1 where children create a pseudo-family arrangement and emulate various roles that are generally performed by different family members. Within this context, gender roles are played out in accordance with perceived and actual cultural expectations. Some respondents suggested that it is within this arena that sexual exploration begins.

Friends and peers were cited as the most prominent source of information about sex. They provide sex information from very early stages in life and this continues into adulthood. One respondent indicated that:

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1 Playing ‘house’, a popular children’s form of play in the 1960s, 70s, and 80s.
We learnt it from our colleagues and boys that you can do like this. A girl has this and that you can use it that way. We used to talk at school and during social gatherings on the streets…. Most boys’ issues or discussions are about girls. We discuss the issues wherever and whenever we meet each other.

The media, largely the internet, also featured prominently in the responses. Children from middle- and high-income families mostly mentioned this, since they had greater access to computers than their counterparts from low socio-economic backgrounds. These findings raise several questions regarding the roles of parents in socialisation. Are parents aware of the different ways in which their children are informed about sex and sexuality? What can be done to avoid misinformation?

In all the areas, it was clear from the findings that the family does not have much input in the education of boys about sexuality matters. Respondents emphasised the difficulty that parents experience in discussing sex issues with their offspring. For instance one said Ke moila le bothldoi mo batsading, meaning that it is culturally forbidden and taboo to discuss sex with one’s own parents. The problem of the limited guidance by elders (in general) was also raised during the stakeholders’ workshop. Participants noted with concern that even informed people continue to demonstrate this shortcoming. They implored society to take stock and try to understand why culture should continue to be an impediment to openly discussing sexual matters with children. One participant identified what he regarded as a lack of ‘inter-generational’ discussions on sexual matters. Rather than attributing it to the limitations of culture per se, he argued that it had to do with the absence of skills and approaches by elders to express themselves to the younger generations on sexual matters. He emphasised that:

*There is a critical need to be gentle and firm in imparting sexuality and AIDS messages to the youth, especially that we all understand that each individual tends to transfer information in a way almost similar to the way they received it. This effectively means empowering the youth for their own survival as well as encouraging them to spread the message in a responsible manner to others.*

**Young males’ relationships with older women**

Another dynamic that was found to place males, especially boys, at risk of HIV infection is sexual relationships with ‘sugar mummies.’ A term usually used to denote older women who enter into sexual relationships with younger males. Most of the respondents attending senior
secondary schools did not seem to find it problematic to have two relationships, one with a girl of the same age and the other with an older woman. Boys and men in all study areas confessed that it was only possible to have one partner if one was committed to her. Otherwise it is not a problem to have two partners. In fact, it was suggested that males tended to enjoy popularity when they had multiple partners.

Apart from providing sexual gratification to their male partners, sugar mummies also offered financial help. Furthermore, these women provide male partners with company and a sense of security. One participant in Gaborone declared that:

_Sugar mummies are fine; they provide us, the underprivileged, with cash. When you have one girl friend there is no security, when she goes you are left alone._

On the other hand, males attending community junior secondary schools did not think it was good to have this type of relationship. This is revealed in their comments below:

_The man is the head of the family, if the woman is older than him it is not good as she will belittle him and not respect him…_

_It is not good to do that._

_It is very bad._

_We do not approve of them altogether. Not at all, it is bad._

The relative absence of community and family-based socialisation agents

In traditional Tswana society, young males and females learned about adulthood issues (including sexuality matters) in initiation schools. The ceremony for boys was called _Bogwera_, while that for girls was called _Bojale_. The climax for _Bogwera_ was circumcision. Initiation schools (including male circumcision) are no longer popular in the country, because missionaries who came to Botswana viewed the ceremonies and practices as evil, outdated, unhealthy and barbaric (Schapera, 1970). However, such schools have not been replaced by any strategy that exposes all young males and females to information about adulthood issues. This is a gap that needs to be filled.

It is, however, worth noting that stakeholders in contemporary Botswana have begun to develop a keen interest in circumcision as a way of combating the spread of HIV and AIDS. For instance, in August 2008, the African Comprehensive HIV and
AIDS Partnerships (ACHAP) of Botswana put out a tender document calling for consultancies to bid for a study on knowledge, attitudes, and practices about male circumcision in Botswana. The Ministry of Health is also exploring the benefits of male circumcision as a means of HIV prevention. There is evidence from various countries that shows that male circumcision reduces the risk of heterosexually acquired sexually transmitted diseases including HIV and AIDS in men by approximately 60 percent (Vincenzi & Thierry, 1994; WHO, 2007).

Inadequate knowledge about HIV and AIDS

Some respondents lacked information about HIV and factors that placed them at risk of infection. This was apparent among respondents in Old Naledi, one of the low-income areas in the capital city. Most work in manual jobs and have little or no education. They believed, for example, that the oil used in condoms spreads HIV, particularly as they do not know its origin. Below are some of their responses:

Condoms make us sick, after we use them, we develop rash on our private parts.

Government is not honest with us. Why can’t he/she tell us the type of oil that is used to make condoms? Maybe the oil used is our totem.³

Yes, it is our totem. Me I know it is our totem, which is why we get sick after using the condoms.

They lamented that they do not have any AIDS education programmes at work, and that the few education programmes that are held in the neighbourhood take place during working hours when they themselves are absent from the area. They felt that only people who work for the government have information on HIV and AIDS.

We do not know a lot about AIDS.

We know that it exists, people with AIDS are slim.

People who come and teach about AIDS come during the week when we are at work.

³ A totem has strong cultural significance – it is regarded as protection for ethnic groups. It is believed that the consumption of any aspect of the animal totem may bring bad luck.
On a positive note, many respondents had received information on HIV and AIDS. The most prominent sources of information included the formal education system, books, magazines, print and electronic media, workshops, the work environment as well as the health system. Most see AIDS mainly as a sexually transmitted disease, which has no known cure. However, a reasonable number of respondents demonstrated a more expanded knowledge and understanding of HIV and AIDS related issues. For instance, one Maunatlala respondent explained:

_HIV is a virus and AIDS is a disease. HIV cannot be seen through a naked eye but through antibody tests. Once infected with HIV, the body is open to any other infection. AIDS is when signs and symptoms start to show, such as diarrhoea and herpes zoster._

The above response serves to underscore the critical idea that HIV and AIDS related information continues to reach the people. By and large, it was evident that people knew how the virus is transmitted and that there is no cure for the disease, which shows that they have sufficient knowledge that can help them avoid being infected. It must be emphasised, however, that high rates of knowledge do not necessarily translate to behavioural change, as is the case in Botswana.

**Male respondents’ views about vulnerability**

Respondents’ views about their vulnerability also placed males at risk of HIV infection. Males who participated in the study did not view themselves as vulnerable to HIV infection. This largely stems from the way they are socialised. Boys asserted that they are taught to be strong and not to reveal their emotions. They like talking about action, not feelings and personal issues. They are made to believe that crying and being emotional is a sign of weakness and only girls should be seen doing it. They are socialised to feel they have to keep things to themselves. A Maunatlala respondent indicated:

_Society expects a man to be brave and hence they take risks and end up being infected._

Most mentioned that females were at a greater risk of infection than males because they are not always in control of sexual matters as compared to their male counterparts. They associated females’ vulnerability with the practice of men having a greater say in sexuality matters than women. For example, in most cases men determine when, how, and with whom to have intercourse. This trend is well documented in existing literature. For example, Tabengwa et al (2001) and Letamo (in press), contend that in
patriarchal societies such as Botswana, the reproductive and socio-economic decision-making lies with the male.

Respondents also associated females’ higher vulnerability to HIV infection with their biological make up. They mentioned that females’ sexual parts are designed in such a way that they are receivers of males’ semen, and this exposes them to HIV. The respondents indicated that in sexual acts, they insert their manhood into females, and were therefore less vulnerable to infection.

They also believed that youth are at the greatest risk of getting infected by the HIV virus because they are highly sexually active and keen to experiment. They expressed particular concern about those who take alcohol and other drugs, indicating that the effects of these include loose morals, loss of self-control and restraint, heightened sexual desire, false self-confidence and, consequently, indiscriminate indulgence in unsafe sex. In a study on alcohol use among persons living with HIV and AIDS in Botswana, Kipp & Kubanji (2007) pointed to the fact that alcohol abuse reduces safe sex practices, and heightens the risk of infection.

Consequently, respondents from all three study areas tended to recommend anti-alcohol and drug use ideas. Some opined that the youth had to be either strongly discouraged or totally banned from entering all types of liquor outlets. Others called for stiff laws prohibiting sales of alcohol and drugs in the country. At the time of writing this paper, the government was advocating a 30 percent levy on alcohol as a means of curbing alcohol abuse. On the other hand, some respondents recognised the need to sensitisie and mobilise men against the HIV and AIDS pandemic. They believed that men needed to be given enough information to enable them to protect themselves and their partners against the scourge. One respondent in Gaborone strongly held that:

*To reduce this (HIV and AIDS), we need to organise programmes at work places and form task groups that would teach us (men) about HIV and AIDS issues and problems affecting men in general. For example, we can arrange some two-day long courses on AIDS issues… This could shed light on men because we have seen these programmes benefiting women, for example, ARVs.*

**Views about sexual relationships between males and females**

Most respondents felt that it is more difficult for men to live without sexual partners than it is for women. It also emerged that men tend to be promiscuous. This obviously places them at risk of HIV infection.
I believe a man should have at least two partners, one in each of the places that he frequents most.

The above quote shows that stakeholders have a mountain to climb to address deeply held beliefs that contribute to the spread of HIV and AIDS. Males’ tendency to have more than one partner in Botswana is not a new phenomenon; it is well documented in existing literature (MacDonald, 1996). Setswana even has proverbs such as monna poo gaa agelwe lesaka (a man, like a bull, cannot be confined to one kraal) and monna phahana oa hapaneelwa (a man is like a shared calabash of alcohol, he rotates among different women). These proverbs reflect that culturally, men are allowed to have more than one sexual partner. Several studies such as that on men and sex conducted by the AIDS/STD Unit in the Ministry of Health show that males are more likely to have multiple sexual partners than their female counterparts (NACA, 2003).

Many of the younger respondents in Maunatlala, however, indicated that they were not in sexual relationships, therefore, it was possible for males to live without sexual partners. Their responses tended to reflect their own circumstances. One respondent argued:

I think it’s possible at my age since my time will come. I heard from the radio that we should not rush for things, which would lead us into problems. But I think for men it is impossible because for a man (as a worker) a woman should be there to help with doing the washing as well as children.

Another respondent provided an equally circumstantial answer:

It is very possible because I do not have a partner, but I still live my own life. As for men I am not sure.

In other words, while these teenagers were sure of the possibility of boys staying out of sexual unions, they could only speculate or assume a non-committal stance in relation to men’s situation. Be that as it may, Maunatlala respondents agreed with their counterparts from the other study areas that a male without a female partner does not normally fare very well in the eyes of society. Such males are normally looked upon with contempt and disdain. Respondents observed that men without female partners are usually assumed to be abnormal or suffering from biological or mental malfunctions. They may be seen to be insane, impotent, gay or suffering from hormonal imbalances. Consequently, according to the respondents, a man without a female partner tends
to attract distasteful labels including coward, ‘suck man’, lehetwa (one who has been surpassed or is ‘on the shelf’), a stupid or toothless dog. This type of anticipated social rejection was cited as one of the reasons driving men into multiple relationships. Such men often find themselves under insurmountable pressure to prove their potency and virility to both their male counterparts and society at large.

Other reasons commonly advanced for men’s promiscuous behaviour included the need to explore, prolonged separation of partners because of working far away from each other, as well as sheer greed. The categories of men that fared quite badly under this assessment emerged as wealthy men and young bachelors, as well as alcohol and drug users. Wealthy men were said to be able to lure women into relations through their resources. However, a participant in the stakeholder workshop cautioned against the practice of making generalisations and reaching conclusions on male promiscuity based on ‘surface observations’ of people’s actions. She indicated the importance of taking time to understand male and female behaviour in a more holistic manner.

**Respondents’ views about why males enter into love relationships**

Males’ views about why men enter into relationships also place them at risk of HIV infection. Respondents from the three study areas drew a common conclusion that men generally enter into relationships for sex. This belief places males at risk of HIV infection because by and large HIV and AIDS in developing countries is spread through sexual intercourse.

Although there were a significant number of responses that some men get into relationships with the aim of ultimately getting married, a majority believed that men tend to desire sex more than any other thing in a relationship. In fact, some respondents noted that men often get married as a way of legally securing their partners for sexual gratification. They pointed out that there is actually no love without sex. Some of them singled out young and middle-aged men as those commonly interested in sex. Their reasons include that these younger males tend to be overly anxious to explore and experiment as well as that they normally have disposable income to spare and exchange for sex.

One of the respondents in Gaborone said the following words to buttress his point: a relationship is important but sex is very important. In other words when you are in a relationship it seems to be obvious to men that it involves having sex. In a few instances boys in junior secondary school stated that relationships were established for companionship. One boy of 17 years of age said that he had had two sexual encounters with his girlfriend, which reveals that sex is valued from a tender age. It is evident from these boys’ opinions what they want in a relationship:
Sexual intercourse comes out outstandingly as ‘what a boy wants from a girl’ especially at our age.

Men and boys want sex, nothing else.

A male participant in the stakeholders’ workshop held in Gaborone, indicated that it would be unwise for women to downplay the significance of women’s dress code while discussing factors shaping male sexuality. He underscored that, while in search of potential sexual partners, men employ the psychology of predators. They assess the vulnerability of their prey carefully. According to him:

Men are like hunting animals. They target the weakest individual in a pack of preys. Women who dress up exposing too much of their bodies tend to be considered more vulnerable compared to those who dress ‘decently’.

He argued that, given a choice between a scantily dressed woman and her more ‘appropriately’ dressed counterpart, the man would normally settle for the former, since she would appear to him ‘more readily available’ for sex. He observed that men’s promiscuity sometimes emanates from the desire to conquer and be in control. According to him, this desire to conquer and control further drives men to believe that they should be able to enter and exit a relationship any time they choose to. Finally, he noted that men keep multiple partners because of insecurity. To this end, he emphasised that a man ‘cannot stand to lose one and lose all at once.’

It was evident from the findings that unequal power relations among males and females with respect to sexual relationships prevail. This serves to confirm the views of previous studies (for example Phaladze & Tlou, 2001) regarding women’s subordination and their related susceptibility to HIV infection. While purportedly having power over females, some of the respondents were aware of the inherent dangers of their own hedonistic behaviour. Other self-defined markers included excessive alcohol consumption, and having multiple female sexual partners. The fragmented way in which boys are inducted into masculinity, as well as the socio-cultural environment tend to expose them to HIV infection.

Implications for sexual and reproductive health strategies

These research findings have profound implications for sexual and reproductive health strategies as shown below. The optimal vision of reproductive health is that
every sexual act should be free of coercion and infection; every pregnancy should be intended; and every birth should be healthy (Tsui et al, 1997).

**The protection, promotion, and fulfilment of sexual reproductive health rights**

The United Nations Population Fund (UNFPA) defines sexual and reproductive rights as:

- Reproductive health as a component of overall health, throughout the life cycle, for both men and women.
- Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one’s children and the right to have access to the information and means needed to exercise voluntary choice.
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender.
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy (UN Population Information Network & UNFPA, 1994:39)

Ensuring the reproductive health of both males and females can go a long way towards safeguarding them against HIV infection. One of the existing mechanisms to promote sexual reproductive health rights of males and females in Botswana is the National Sexual and Reproductive Health Programme, which aims to, among other things, reduce the incidence of rape by 50 percent and to increase male involvement and participation in sexual and reproductive health by 50 percent (MoH, 2002). The Adolescent Sexual and Reproductive Implementation Strategy is also worth noting. Included in the aims of this strategy are to ensure that the services are adolescent and youth-friendly; and that they are comprehensive and of high quality. Despite the existence of programmes, much still needs to be done to address the socio-cultural factors that place males at risk of HIV infection that are discussed in this chapter.

**Conclusion and recommendations**

The following recommendations may assist in addressing socio-cultural factors that place males at risk of HIV infection, hence improving their sexual reproductive health. First, males need to be sensitised about the importance of gender equality. This is so because males’ attitudes and behaviours are strongly influenced by society’s expectations, therefore, promotion of gender equality and equity is of paramount importance. Males’ sensitisation to the need for gender equality would go a long way to encouraging males to safeguard their reproductive health as well as that of their partners, a trend that would reduce the risk of HIV infection. This is crucial, taking
into account the findings of this study, which revealed that unequal power relations between males and females in sexuality matters place males at risk of HIV infection.

Second, it is important that current health programmes are made user-friendly to males. More females than males have always utilised sexual reproductive health programmes, particularly maternal child health and family planning services. In recent years, stakeholders have been encouraging males to play an active role in sexual reproductive health matters, by, for example, accompanying partners to family planning services and maternity services. However, some health workers see men who accompany partners to these services as intruders. It is therefore important that health workers are sensitised about the need to be friendly to males.

Third, there is need to socialise boys to adequately resist peer pressure. Information and education efforts that aim to reduce the influence of peers on males sexual behaviour should be intensified because, as shown elsewhere in the chapter, information from peers tends to be sensational and encourages early sexual activity – a behaviour that places males at risk of HIV infection.

A related point is that it is crucial to empower parents and guardians with communication skills so that they can communicate effectively with their children about sexuality issues. This could be spearheaded by child welfare organisations, by boys themselves, as well as by individuals who advocate for the rights of males. Boys could be trained to be peer counsellors so that they can empower their counterparts who are facing challenges such as peer pressure. This involves equipping boy children with proper survival skills to enable them to ward off the harsh pressures of the world. Unfortunately, boys are left out when girl children are actively empowered with these survival skills. This is important since what children learn in childhood tends to develop with them as they grow into adults. Most importantly, the behaviour patterns adopted by male and female adults tend to reflect what they learned in childhood. The finding that peer pressure influences young males into early sexual activity, placing them at risk of HIV infection is not a new one. It has also been documented by scholars such as Maundeni (2002).

Lastly, it is important to note that the findings of this study cannot be generalised to the whole population of males in Botswana due to the small sample size. It is, therefore, recommended that in the future, large-scale studies on issues of males and reproductive health (including HIV and AIDS) should be conducted. Such studies should include males from a wide range of backgrounds because males are not a homogenous group.

This chapter highlighted several socio-cultural factors that place males at risk of HIV infection. It has also presented some strategies that could go a long way to addressing such factors. It is widely believed that the active involvement of males in HIV
research, programmes and policies could curb the rapid spread of AIDS in the country. However, it must be acknowledged that socio-cultural beliefs, values and attitudes do not usually disappear overnight. Nevertheless, if rigorous efforts are made to address them, change will occur in the long run. The study of male risk illustrates the need for further research that focuses on the social construction of gender and masculinities. The research should raise further questions about the interface between the impact of macro-level structural forces such as culture and the economy on sexuality and sexual behaviour, as well as the micro-level negotiations of sexuality, and their impact in spreading and reducing the spread of HIV in Botswana.

References


World Health Organization Bulletin. 2007. **Male Circumcision for HIV prevention.**
Chapter 3

Disempowerment + Blame = Zero Male Involvement in HIV and AIDS Issues

Kgomotso Gertrude Garegae and Marina Rinas Gobagoba
Little or no male involvement in HIV and AIDS interventions continues to be a major concern to both governments and civil society organisations. This is because it negatively impacts on the fight against the pandemic. Men need to be involved in sexual and reproductive health particularly on issues of HIV and AIDS for a number of reasons, including the fact that they often have multiple partners and yet are not keen to use condoms (Phaladze & Tlou, 2001; Walston, 2005). Their promiscuity not only makes them susceptible to HIV infection, it also endangers their wives and partners. Men have control over sexual matters most of the time, and as such they coerce their partners to have unprotected sex, thus making these women vulnerable to infection.

If men were more involved in HIV and AIDS interventions, they would take responsibility for their actions and change their risky behaviour for the better, as well as assist women with caregiving and chores such as collecting water and firewood. Male involvement in issues of HIV and AIDS is important for successful utilisation of existing interventions such as the PMTCT programme. The success of this intervention depends on the support and involvement of the spouse. The 2004 Botswana Millennium Development Goals Report indicates that stigma and discrimination have contributed to the under-usage and failure to implement the PMTCT programme (Republic of Botswana, 2004). According to the report, the stigma surrounding the disease remains one of the greatest barriers to the implementation of various care and prevention strategies. As a result of this stigmatisation, wives and female partners are reluctant to inform their male partners about their enrolment in programmes.

Men’s involvement in HIV and AIDS intervention programmes has some potential in producing beneficial outcomes in terms of an increase in attendance at health facilities, adherence to condom use and antiretroviral intake, as well as the elimination of rape and child molestation. Despite the possibility of these positive outcomes, very few men assist women in providing care and support to people with AIDS. The chapter attempts to explain the negligible male participation in sexual and reproductive health, with particular emphasis on HIV and AIDS.

The chapter starts with a discussion of three theoretical constructs, namely, disempowerment, the self-fulfilling prophecy and the blame game as reasons why males are reluctant to participate in programmes aimed at fighting the HIV and AIDS pandemic. This is followed by an analysis of the gendered division of labour in the family. Thereafter, male
disempowerment, self-fulfilling prophesies, and the blame game are analysed in relation to childrearing practices in Botswana. The chapter ends with a discussion of implications for HIV and AIDS interventions targeting men and boys.

**Theoretical constructs**

The three theoretical constructs of disempowerment, self-fulfilling prophecy and the blaming syndrome are useful in explaining the lack of or minimum male involvement in HIV and AIDS programmes. Each is discussed briefly below.

**Male disempowerment**

At the time of birth, no child is wired with the capabilities of performing one task rather than another. The gendered roles for both boys and girls are learned through primary socialisation and perpetrated through secondary socialisation (Kaiser, 1996). In these roles, men grow up knowing that women take care of the home and men provide basic needs for the family.

They learn these habits from their parents. For instance, the boy child is taught, through verbal and non-verbal cues and cultural activities, that men should be strong, brave, independent and self-sufficient. They are told that the family depends on them for survival and the perpetuation of the family name. Regardless of their age, males are given responsibilities that sometimes overwhelm them. For instance, in the case where a family requires basic needs such as food and clothing, a boy child is told to go and look for a job, where and how does not matter. This demand at times propels boys into theft and burglary.

Differential treatment between boys and girls is evident when they go to school. Where there is a long distance between school and home, the boy is allowed to go without the parents fearing that he will be hurt on his way to school, but the girl is restrained by the fear of her being raped or hurt. From such differential treatment, a boy learns that he is not only strong, but also stronger than a girl.

The other lesson that boys get from the differential treatment is that what happens to them matters less than what happens to their sisters. The fact that they are allowed to risk impending danger, sends a strong message that their emotional well being is of little value to society in general, and to their parents in particular. Thus, they learn to do things single-handedly without the help of others. Because they are associated with hard work and bringing food home, they:
have learned to identify with (their) work, even if it is not a matter of finding personal fulfillment but simply earning a wage. …. We learn in diverse ways to conceal hurt and pain and to take pride in experiencing pain as a sign of our strength. (Seidler, 1992:11).

In this process, more boys than girls may learn to suppress their feelings, and so do not usually express emotions, at least in public. For instance, during funerals men rarely shed tears even if they have lost a spouse or a child. Seidler (ibid:12) describes this behaviour:

We had learned so long to present ourselves in particular ways and to deny our emotions and feelings... But it was often still difficult to communicate our feelings within our personal and sexual relationships. It is partly because we express so little as men that we fear being overwhelmed and overwhelming to others.

In order to maintain this detachment from their emotions, men get absorbed in various tasks, rationalising their emotions as subjective and unimportant. As a result, it becomes difficult for them to accept their vulnerability as an integral part of their male identity. This attitude has implications for their emotional maturity. For example, they may not be ready to handle any relationship. Instead of working as a community, men prefer to work alone, contrary to the African philosophy of co-operativeness. Seidler (ibid:1) comments:

male identity is sustained through our capacity for not needing the help of others. We learn to take pride in our self-sufficiency and we experience it as a sign of weakness to need the help of others.

The message in the paragraph above has implications for the nature of activities that men engage in, and perhaps explains why they are reluctant to join hands with women in the fight against AIDS. In HIV and AIDS issues such as home-based care, adherence to antiretroviral treatment, and the PMTCT programme, support from family members and significant others is necessary and essential. If men take pride in self-sufficiency, they are unlikely to be involved in such issues.

When working as a group, each member should be sensitive to other members’ feelings and emotions, and choose appropriate words while interacting. Also, one must be connected to his own emotions in order to be responsive to others’ emotions. But we learn from Seidler (ibid) that men are not only unaware of their emotional needs but also
lack the vocabulary to express them because ‘Growing up in a competitive culture means that to have needs is a sign of weakness and a compromise of our male identity’.

As a result of men’s ‘dead’ emotions, they learn to trust no one with their secrets, and when overwhelmed, resort to anger. Anger protects male identity in that it acts as a repellent that keeps others from seeing men’s vulnerability. In her study on how teacher counsellors cope as they help those infected and affected by HIV and AIDS, Garegae (2005) found that only teachers who have accepted their status were able to help others. Therefore, for men to participate in HIV and AIDS interventions, they need to be helped to accept their emotional vulnerability.

Another disempowering message learnt by boys at a tender age is that men should not be engaged in household chores. Usually, mothers prepare food and wash clothes for their sons but require their daughters to learn to do the same chores for themselves. This leaves boy children without any knowledge and skill of how to take care of themselves when they come of age. In this process of illusive loving, boys learn to associate girls and women as supporters of their physical and emotional needs. For instance, an elder brother expects a younger sister to do household chores for him. Therefore, everyday family norms and practices disempower men from acquiring skills necessary for homemaking and caregiving.

**Self-fulfilling prophecy and male fraternity**

After men have learned that characteristics such as emotional self-control, bravery, audacity, and the inability to do home chores are associated with masculinity, they behave in accordance with these expectations through the process of the self-fulfilling prophecy. The self-fulfilling prophecy is a process in which an individual acts according to expectations ascribed to him by others. According to Tauber (1997), the self-fulfilling prophecy has four elements. First, it is the climate in which the socio-emotional mood is displayed. This mood tells the individual if she or he is accepted or not. Second, is the feedback in which both affective and cognitive differential responses such as praise or criticism are given to an individual depending on whether or not she or he is favoured. Third, is the input that an individual receives in terms of their differential treatment. This manifests itself when boys are given preference in terms of education and freedom over girls.

The fourth element of the self-fulfilling prophecy is the output where verbal and non-verbal cues are used to communicate expectations to an individual. This would involve telling the boy or acting out messages that he is superior, braver, and a more appropriate family heir than his sisters. These messages are internalised and the boy child, as he grows (McLeod, 1992), feels obliged to keep the status quo because ‘people depend on one another for their identities’ and hence:
when we realise others are responding to an identity, even when it is not the most salient to us at the moment, it is a form of social feedback that we may interpret and use it in understanding ourselves through the eyes of others (Kaiser, 1996:190).

Consequently, boys continue to suppress their vulnerability in relationships. And as:

we block our feelings, we also block our love, for love is related to vulnerability. So it is that we learn to fear intimacy, for we often find it hard to share our vulnerability without feeling that we are somehow being compromised as men (Seidler, 1992:15).

If there is an issue to be discussed, men abruptly cut communication before an amicable solution is reached. And society endorses this behaviour by praising men for being neither talkative nor petty. Because this bullying behaviour is reinforced, they become physically and emotionally abusive, and exploit women in whatever manner they wish. They cherish being understood rather than understanding their partners.

In the public realm, men become leaders and in some cases, they ‘force’ themselves into positions of higher standing as an act of audacity. Circumstances surrounding the man’s life, as a father and a husband, and expectations thereof, coerce him to live up to societal standards and in the process may ‘oppress’ women in senior positions. Sometimes this harassment may result from intimidation that he is not man enough because his supervisor is a woman; all of a sudden he is now inferior, contrary to what he has learnt since childhood.

Men’s reluctance to participate in HIV and AIDS interventions may result from this intimidation. It is a known fact that community service is a feminised sector (Smith, 2005). Smith found that more women than men serve as volunteers in social activities. If men indeed love to prosper in the public domain, which is defined by money and prestige, they are unlikely to be interested in private domain activities, such as care and support, where there is little recognition and no monetary reward. This attitudinal preference is largely influenced by the way the boy child is raised, and this legacy is perpetuated by the process of secondary socialisation. The process becomes the basis for learned helplessness where boys and men believe that they are unable to perform domestic tasks – and act in accordance with the expectation of others who in turn blame them for being insensitive to others’ needs.

**The blame game**

The blame game has been with humanity from the Garden of Eden as recorded in Genesis 3. In response to the question ‘who told you that you were naked’, Adam said ‘the woman you put here with me’ thereby blaming God for giving him Eve (Manikas-
The lesson derived from this scenario is the human propensity to transfer culpability to another person.

However, the hegemonic tendencies of men should not only be blamed on men themselves but also on females and society at large. After achieving success in disempowering the boy child, society then turns around and puts the blame on him for being insensitive. This blame gets displayed in various ways, both directly and indirectly. The messages in the media and other forms of medium bluntly blame men for being unrealistic, emotionally detached and not caring for the emotional needs of their loved ones. The picture that is painted is that men are inhuman and as hard as stone. As a result of this portrayal, women and children fear the adult male in the house, and can neither appeal for emotional help nor confide in him. As it becomes part of their daily routine, children of both sexes internalise these experiences and transfer them to the next generation, and the process becomes a vicious circle.

Blaming male’s lack of involvement in HIV and AIDS interventions, and in particular in sexual and reproductive health, becomes problematic if they are perceived as foes instead of partners in this battle. This distrustful attitude may give birth to the spirit of antagonism that acts as a repellent between the two sexes. It is understandable that men are reluctant to participate in the provision of care and support to those who need it. In psychology, it is observed that when people are blamed, especially for something beyond their control, they build a defensive wall around them. This wall is like a hibernating shield that helps them to be numb to the accusation. In such a situation, the victim is not helped to engage in self-introspection in order to challenge the deep-seated beliefs that have been ingrained since childhood and through secondary socialisation (Kaiser, 1996). Rather, the behaviour is allowed to perpetuate.

Similarly, men are denied a set-up in which they can gain knowledge of the dynamics of the patriarchal system and how gender segregation of domestic duties came about. In the absence of this conceptualisation, men are likely to weave an egocentric mantle to protect them from exposing their inadequacies. But their involvement is indeed a method of liberating them from the veil that actually enslaves them.

**Gendered division of labour in the family**

The three constructs that contribute to relatively little male involvement in HIV and AIDS initiatives should be understood within the context of the Tswana cultural settings that define gender relations. The traditional role of men in a household is that of decision-making, hence the saying *ga di ke di etelele ke managadi pele* (females should not lead). However, decisions at the centre of family welfare such as nutrition, clothing, health care and emotional support, are the responsibility of women. Consequently, women
perform all the household chores including cooking, cleaning, washing clothes, and caring for the sick. Men, on the other hand, who are often outside the home, are tasked with the responsibility of being breadwinners for both nuclear and extended families.

Men’s involvement is visible in social activities such as marriages, funerals, and arbitration. Even so, the extent of their involvement depends on their position at that particular time. For instance, a man may play multiple roles, such as that of an uncle, giving him the prerogative to authorise the proceedings of his niece or nephew’s wedding. The uncle’s authority is also felt during funerals where he marks out his niece or nephew’s grave. By contrast, in most social activities, such as baby showers and church services, male attendance is slim. It appears that men are not comfortable in settings where women are predominant. A pastor in one of the charismatic churches in the United States of America observed that men absent themselves from church assemblies because ‘it is too feminine’ (Religion and Ethics News Weekly, 2006). Men claim that what churches teach is in conflict with male identity:

Over the years there’s been a gradual feminization of a lot of our [church] practices. There’s been an emphasis on relationships, nurturing, close-knit communities. Men are into challenge, adventure. Men, especially young men, like conflict and change, and these are the sorts of things that are downplayed in church today.

It seems men are deflected from places where nurture is promoted. That is why the church interviewee in the above quotation calls for a church environment that is different from the present one of high emotions and harmony. Men also prefer contexts where no one emasculates them. At church, the pastor gives orders and church members must obey them. According to men who commented on Pastor Doebler’s interviews, males prefer going to bars and pubs over going to church because in bars no one is superior to the other. This is illustrated in the following comment:

I have seen (that) men feel more comfortable after the service is over, joking in the parking lot, or sharing stories in the hallway, than they do while warming a bench during the service (Religion and Ethics News Weekly, 2006).

Although history shows men’s involvement in social activities, they do not exert themselves in all of them. Men do not help in almost all household chores such as cooking, looking after siblings and caring for the sick. In addition, men have shown a lack of interest in other community activities such as participating in parent-teacher associations, village development committees and home-based care. This lack of
involvement in community services is not a problem peculiar to Botswana, but an international one as noted by Smith (2005).

The trend of men’s lack of participation in home chores, the provision of care and emotional support has been accepted throughout history until just recently with the advent of sexual and reproductive health problems. Men’s involvement is needed in the caring of the sick, especially those with HIV and AIDS who are bedridden. Society, on the contrary, has not empowered men to share their emotions with others. Emotional support has always been the prerogative of the female folk. Men’s refusal to provide care and support to their family members has implications for their involvement in HIV and AIDS interventions.

**Male disempowerment, the self-fulfilling prophesy and the blame game in Botswana child-rearing practices**

Traditional education in Botswana, like in any other African country, is both functional and gender polarised. Basically, the aim of this education is to teach children to be obedient, responsible, hard working, and self-reliant, and also teach them about nurture. From infancy, boys are taught to behave like men and girls like women. This education is expressed through verbal and non-verbal cues in terms of instructions and assigned activities. While the boy child is exposed to activities that will initiate him into manhood by males, the girl child is similarly exposed to feminine activities that will mould her into womanhood (Mgadla, 2003).

Although both children are taught responsibility, how this concept is interpreted differs according to their sex roles. As an illustration, the boy child stays at the cattle post, where he learns how to tend cattle by spanning them, milking, building kraals etc. When a cow goes missing, he does not rest until he finds it. He learns the value of cattle rearing and equates the number of cattle with wealth. While at the cattle post, this child is subjected to hardships such as a shortage of food and water. He is indirectly being denied all the luxuries that his female counterparts may be enjoying at home. In the process of becoming responsible, he learns to suppress his emotions and becomes iron-willed and uncompromising. These same characteristics are seen in his later years as being selfish, egocentric and emotionally distant.

On the other hand, a girl child’s responsibility is defined in terms of nurturance and obedience. While her brother is in the bush, she is charged with the responsibility of caring and supporting him by preparing his food, laundering his clothes, cleaning his bedroom, etc. In the process, she consciously or subconsciously learns that her domain is that of servitude – making sure that her brother is comfortable. She grows into a compassionate person, and interpersonal relationships become more important.
to her. This learned behaviour turns into passive obedience, which in most cases predisposes girls and women to sexual and spousal abuse, because males have learnt and experienced a superior social status.

**Implications for HIV and AIDS interventions for men**

Men have their own unique way of knowing and experiencing the world around them, which differs from that of their female counterparts (Belenkey et al, 1986). For instance, while men rationalise issues and treat them abstractly, women value context. Men also prefer ‘a collegial and fraternal atmosphere of equality where they feel comfortable and loved’ (Religion and Ethics NewsWeekly, 2006). This information is crucial because the practice is to assume that men learn the same way as women although gender differences are acknowledged. It is imperative, therefore, that organisers of HIV and AIDS interventions are aware of possible barriers to men’s (and women’s) learning styles.

There are essential points that need to be taken into consideration when preparing for men’s involvement in sexual and reproductive health within the framework of the HIV and AIDS pandemic. Men are taught to be detached from their emotions. It is not easy for a person to provide care and emotional support without being sensitive to his or her clients’ feelings. To prepare men to help women in the HIV and AIDS battle, they need to be taught how to connect with their emotions. Studies on how caregivers cope with HIV and AIDS challenges showed that the provider has to be humane – ideally, the caregiver should be emotionally mature, be able to cry when necessary, and laugh in the midst of pain. Thus, HIV and AIDS interventions for men should provide emotional education.

Related to the above is the fact that men are taught that vulnerability is anti-masculine. It is illusive for men to believe that they do not need assistance from others. As social beings, people need each other for warmth and love. By being engaged in community service, volunteers acknowledge that man is not an island. Men need interventions that will make them unlearn the spirit of competition and self-sufficiency, unlearn the pride of individuality and replace that with the strength of team work: *kgetsi ya tsie e kgonwa ke go tswaraganelwa* (team work is better than working alone).

Connected to human vulnerability is the ability to trust another person. People who do not trust each other cannot work together well. Being involved in home-based care, for example, requires working together and the members of the team need each other for emotional support. But men do not want to be led. They are also impatient. As a provider of care and support to terminally ill patients, patience becomes a virtue.
The use of condoms and other preventive strategies also requires patience. Society gave the boy child the impression that he is superior to his female counterpart. Thus interventions should help men understand that they are born and fed the same way, vulnerable in like manner, and die as women do. It is not easy for them to grasp the idea that both genders are born with the same strength, but that society had assigned different roles to males and females. It is important to note that men may be reluctant to provide care and support in HIV and AIDS related interventions because of the perceived stigma.

Engaging men in sexual and reproductive health may prove to be difficult if the effects of socialisation are ignored. Since men know that society has little expectation of them in providing care and support, they may learn to be helpless. This translates into a lack of will to combat the effects of culture. Instead, they attribute their failure to innate abilities, and as such may be prone to fear and anxiety whenever they hear the words HIV and AIDS.

**Strategies to involve men in health issues**

Taking all impediments into account, the following strategies are suggested for maximising men’s involvement in issues of health.

1. It is important that educators establish a warm social-emotional relationship with participants by removing any barriers that could cause an intimidating atmosphere. This means that educators should be familiar with how men understand their environment so that their egos are not hurt. One way of doing this is guaranteeing men’s confidentiality.

2. Educators should give men feedback about their performance and acknowledge their efforts.

3. Educators should give participants diverse material in order to expand their knowledge about the HIV epidemic. Such material should also help men unlearn what society has taught them about their superiority over women.

4. Interventions should give men more opportunities to respond and ask questions. Although men seem reluctant to be involved in community issues, especially home-based care projects, society should not lose hope. Men need support and encouragement from society, especially from community leaders such as pastors, chiefs, councillors and Members of Parliament.
Conclusion and recommendations: The need for a sympathising heart

This paper discussed male disempowerment by society and their learned helplessness as factors hindering men’s involvement in HIV and AIDS intervention programmes. It argued that the socialisation that is mostly performed by parents predisposes boy children to be reluctant caregivers and homemakers. Based on this discussion, the chapter recommends interventions that are male inclusive in the form of HIV and AIDS campaigns that do not undermine men’s intelligence to ensure successful outcomes. The concepts used should reorient, rather than undermine men. Interventions should be careful not to use a ‘blame’ approach, as this will demoralise men.

We argue for holistic intervention programmes as opposed to cosmetic and abstract ones which address only one sex – be they males or females – because such is counterproductive (Foreman, 1999). The ‘need for a sympathising heart’ points to formulating programmes that recognise that emotional or psychological scars take time to heal. Bringing the boy child and men aboard on issues of HIV and AIDS is like rewinding the socialisation wheel, which will not necessarily be easy. A conducive environment that gradually empowers men to recognise their vulnerability to HIV and AIDS needs to be created by intervention organisers; one that is not based on blame.

Intervention developers should re-examine interventions for empowering women. Many of these have been successful because they do not blame women; indeed, women receive sympathy from both policy makers and implementers. The same attitude should be extended to integrate men in issues of sexual and reproductive health with an emphasis on HIV and AIDS. A male friendly environment is essential if the implementation of interventions for male involvement in HIV and AIDS issues is to succeed.

References


Chapter 4

Male Involvement in Antenatal Care and Prevention of Mother to Child Transmission Programmes in Botswana:

Results of a qualitative study

Sadasivan Nair and Serai Daniel Rakgoasi
Botswana has achieved significant development in areas such as poverty alleviation, access to resources, education, health and employment since independence in 1966. It has emerged from being one of the poorest countries in the world to a middle-income developing country. However, these gains, unfortunately, are now seriously threatened and are being reversed by the HIV and AIDS epidemic. Botswana ranks among the hardest hit of countries with an HIV prevalence of 17.4 percent (CSO, 2005) among the general population.

The AIDS pandemic has had a gender bias across the world. The lack of women’s empowerment in the face of prejudicial cultural and traditional practices and in decision-making around sexual and reproductive health issues has been identified as a crucial factor contributing to women’s vulnerability to HIV infection. Increasing poverty among single female-headed households and the rise in the incidence of violent acts against women are other contributing factors, especially in Sub-Saharan Africa. Unless these factors are addressed, no significant achievement can be made, no matter how much is invested in the interventions in terms of resources – materials, human and time (MFDP, 2003).

The lack of active involvement and support of men in antenatal and postnatal services and HIV management in particular is a related area of great concern, especially in this region. VCT is an important tool in HIV and AIDS prevention and with appropriate counselling and support, it is likely that individuals will adopt behaviours that would lead to a reduction in HIV transmission. However, these free services do not attract men in a significant way. Only 19.5 percent of males in the age group 10–64 years have been tested for HIV as against 30.3 percent of women in the country. Similarly, only 10.2 percent of men have been counselled for testing at least once, as against 17.8 percent among women (CSO, 2005). According to recent statistics, the role of men in programmes such as the PMTCT in Botswana is only 10 percent (UNICEF, 2004). Counselling services offered at the antenatal clinics motivating both women and men to test their HIV status and the consequent actions needed also are not adequately effective, for men in particular. Again, social stigma and fear of discrimination and abandonment by partners, family and friends are also reasons for the lack of progress in HIV prevention. Here too, enhanced male involvement could prove critical.
With this backdrop, the study conducted aimed to unravel various aspects of the role of men in antenatal care service utilisation, the PMTCT programme and VCT in Botswana.

The research had three main objectives:
1. to study the levels of knowledge, attitudes and perceptions of men and women towards the utilisation of antenatal care services, VCT for HIV and the prevention strategies of HIV and AIDS, especially, PMTCT
2. to find out the reasons why men do not accompany their wives or partners to antenatal service clinics; and
3. to find ways and means to enhance men’s involvement in antenatal care and to promote PMTCT.

This chapter is organised as follows: The methodology adopted for the study is discussed, providing information on the sampling design used, study areas and the data collection strategy. The next section deals with the findings of the study. A brief summary of findings including policy recommendations is furnished in the last section.

Research methodology

Demographics: Four sites were selected for the study, two urban and two rural. For this, Botswana, which consists of 22 health districts, was first divided into two broad regions: north and south. The two most important urban areas, Gaborone and Francistown, were selected purposively from the south and north regions respectively. The rural sites, Molepolole and Masunga, were chosen randomly from the list of health districts. Two health facilities from each site were again selected on a random basis from among the largely attended facilities in the selected sites. These areas served as the base for recruiting focus group discussion participants from the women attending antenatal clinics. We conducted at least two focus group discussions in each health facility; one for women and one for men. Thus, a sample of eight health facilities from across the country was selected for this study.

Procedures and participants: Data collection techniques envisaged for this study were qualitative, primarily focus group discussions and in-depth interviews. For this, four research assistants, who possessed at least an undergraduate degree in social sciences with some previous relevant experience, were recruited. Participants for the focus groups were enlisted at health facilities and in the community, especially for male participants. A focus group discussion guide was prepared for use by the research assistants. A separate interview guide, linked to the focus group guide, was also used.
for in-depth interviews. All focus group discussions were conducted with the close supervision of at least one of the authors.

In order to maximise group homogeneity, particular attention was paid to certain socio-demographic characteristics in each group of participants. For example, focus group discussions for younger women were separate to those for older women, and also those belonging to varying socio-economic profiles. A similar approach was used when selecting male participants as well. Since we did not expect to find a lot of men attending antenatal clinics, men were sourced from the community through a combination of house-to-house calls, as well as targeting certain areas or institutions where they are likely to be found, such as kgotla and public works places, and through consultation with community members. A total of 16 focus group discussions were conducted in the four sites, at a rate of two per health facility (see Table 1).

### Table 1: Focus Group Discussions Conducted by Site, Sex and Age

<table>
<thead>
<tr>
<th>Site</th>
<th>Sex</th>
<th>Youth (16–29 years)</th>
<th>Adults (30+ years)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaborone</td>
<td>Male</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Francistown</td>
<td>Male</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Molepolole</td>
<td>Male</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Masunga</td>
<td>Male</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>8</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

In addition, in-depth interviews with key informants were also held within the community and at health facilities. A key informant is someone who has a good or unique experience of the subject at hand, either by virtue of practical experiences or profession. In our survey, key informants were facility health workers, social workers, counsellors, and religious and community leaders. Both the focus group discussions and in-depth interviews were recorded using micro tape recorders. Further, the ‘note taker’ also gathered information, especially on non-verbal communication, which can be of immense help in qualitative research. The tape recording was essential so that the transcriptions could use exactly the same words to avoid loss of meaning and ensure clarity of information. Transcription of the data collected through the discussion groups and in-depth interviews was done at the end of each day. This was important for ensuring the interview was still
fresh in the minds of the transcribers. Later, transcribed data from both men and women who participated in the focus group discussions and in-depth interviews were analysed in a descriptive manner.

**Research findings**

**Knowledge about antenatal clinics, VCT, and PMTCT**

From the discussions with men and women in focus groups, it was clear that there exists, by and large, a very big gap in terms of men and women’s knowledge about antenatal clinics, PMTCT and VCT.

Of course, women are more knowledgeable. Women reported that they become aware of antenatal clinics by seeing fellow women going to the health facilities every month when they are pregnant. A large variety of sources such as health talks and posters at health centres, television and print media are reported as the main sources of information on antenatal clinics and PMTCT among women. Women also demonstrated more in-depth knowledge of how the antenatal clinics and PMTCT programmes relate to each other, the process of enrolling, and the post delivery stage. The following quote illustrates this:

*I know when a woman is pregnant she goes to the clinic for check up, to see if she and the baby are okay, also to check if she will deliver properly. They also take her blood and test it for HIV and AIDS at the antenatal clinic, and if she is found HIV positive, she is enrolled for PMTCT. It is a very good programme, it has saved a lot of lives in this country. I know about it. I also know that when you have enrolled for this programme, you are not supposed to breastfeed your baby* (Old Naledi, Gaborone, elderly woman, 14 July 2004).

Men reported that the only reason they are aware that expectant women should go to the clinic every month is because they see women (spouses, partners, relatives etc) doing that. But men seemed to have only some awareness and not sufficient knowledge about what antenatal clinics do. Only a few reported that their partners always give them reports of what was done at the clinic sessions, and explain what any tablets or supplements are for. Some reported that they never bother to ask about the antenatal clinic sessions because it is considered a woman’s exclusive domain.

Men not only tend to rely on their partners as sources of information on antenatal clinics and PMTCT, they also use their partner’s HIV test results to infer their own HIV status. What is surprising is that while an HIV positive partner would lead the man to assume that he is also HIV positive, a negative HIV test
result does not seem to motivate men to undergo HIV testing. This was captured by the response of one young man:

_Talking from experience, what I can say is that, there are issues that we don’t understand. Let me give you an example, when my girlfriend told me that she was ok, I automatically assumed that I was ok too… She went there for the second time, and she was still negative and I have slept with her. I am relaxed now, even though from the beginning I wanted to go for testing, now that she is negative I don’t see the need to go for testing. This has proved that I am HIV negative, so I have to take care of myself not to be infected_ (Old Naledi, Gaborone, 16 July 2004).

Generally, women felt that the main reason for the lack of adequate knowledge about antenatal clinics, PMTCT and related programmes among men is their lack of genuine interest, rather than inadequate sources of information. Women felt that they share the information with their partners, and that if the men were interested, they would follow up to learn more, as these comments from young women in Old Naledi indicate:

_They hear from us and partners and if the man is not interested he will not understand._

_It is not enough. He should go with us to the clinic so that they can hear for themselves._

_We want our partners to go with us to the clinic but as you know men don’t. They just take it as a woman’s problem_ (14 July 2004).

The unequal access to sources of information between men in rural and urban areas was also recognised as a factor that might cause rural men to be more ignorant, relative to their urban counterparts. Discussants noted that information and educational materials tend to be concentrated in urban areas.

The inadequacy of knowledge about antenatal clinics is rather discouraging, especially among men. This was a typical male response:

_I always hear that they (women) are massaged at the antenatal clinic; but I will ask a traditional midwife to do it for her rather than let her go to the hospital_ (Francistown, young man, 25 July 2004).
So, ‘massaging the abdomen’ of a pregnant woman is perceived as the major service provided in antenatal clinics. Men also have only limited knowledge of the existence of programmes like VCT, and PMTCT. Knowledge about how mother to child transmission occurs or how ARVs function to reduce such transmission was also very limited. A considerable number of respondents did not understand how a child born of HIV positive parents can not be HIV positive because, according to them, a child is formed by the ‘fusion of blood’ from both parents. Some respondents thought that ARVs destroy the HIV virus in the foetus. As such, they wondered why the mother also cannot be saved. Some men felt that there was even a conspiracy to save only the child and not the parents:

*Why can’t they just increase the dosage and destroy the virus in the mother’s blood also?* (Molepolele, elderly man, 20 July 2004).

Very few men attempted to give any details of what either the antenatal clinics or PMTCT programme entails. Those who did were very vague. In contrast, women were not only more knowledgeable than men about the antenatal clinics, VCT and PMTCT programmes, some also shared personal experiences acquired through these programmes.

*To tell you the truth, I heard about it from their caravan while I was pregnant. They encouraged me to go for testing and when the results came, I was taught about PMTCT* (Old Naledi, Gaborone, young woman, 14 July 2004).

In any rural society, Africa in particular, traditional leaders or chiefs play a decisive role in influencing people’s attitudes and perceptions. They command respect and credibility among people, especially in rural areas. Therefore, the level of knowledge among these leaders is crucial for the effective implementation of HIV management programmes. Unfortunately, our study points towards serious lacunae in this direction. A chief in Molepolole remarked during our discussion:

*I only learn these things from the radio. I think if we were taught, we would understand these programmes better. Since we are leaders of the village, we would be advising people concerning these programmes. Now that we don’t know anything, there is nothing that we can tell them* (Molepolole, chief, 19 July 2004).

This is a lost opportunity because traditional leaders have ample opportunities to address their constituents at *kgotla* meetings, funerals and other gatherings,
and also to garner public support for the idea of men’s involvement in these programmes. They have the leverage to influence public opinion and perceptions of certain programmes, including the spread of the message of male involvement. This lack of knowledge implies that traditional leaders are less likely to talk with conviction about the need for male participation in antenatal clinics and PMTCT programmes.

Attitudes and perceptions towards antenatal clinics and PMTCT programmes

Generally, both men and women understood the importance of antenatal clinics and PMTCT programmes and were supportive of their declared intent. From the discussions held, it became apparent that there is a widespread societal expectation that a woman should register with the clinic before the beginning of her fourth month of pregnancy. At the clinic, women are expected to get all the information about antenatal clinics and their various service components from health workers. However, across most male groups, the antenatal clinics and PMTCT programmes are still viewed as the women’s domain, with very little role for men. This perception was even echoed by village chiefs. Male chauvinism is also a barrier in this context.

*When it comes to antenatal clinics, not most men know about. It is a woman’s secret and so she will handle it alone. I think if you take your partner when you go for antenatal clinics, he will understand better what is going on* (Old Naledi, Gaborone, young woman, 14 July 2004).

*As for me, I will go to ANC with my partner when she is pregnant but when it comes to testing for HIV and AIDS, I will refuse because I know I have been having sex with her only, so why do I test? I am the head of the family and what I say goes* (Francistown, young man, 25 July 2004).

In a society where marriage, as a social institution, has weakened considerably, it is not strange to find that married women do not want to risk their married state. This is evident from the following typical responses:

*It is true that women are afraid of rejection. Some men are abusive to their partners, and some don’t even go to the hospital even when they are sick. Some men are very cruel. They abuse their partners, so when there is a problem, a woman will be scared to tell her partner because she is afraid of rejection or abuse* (Masunga, elderly woman, 24 July 2004).
This programme is for women only. The transmission is from mother to child, so it’s for women, and men are not involved. I do not have any obligation to attend (Francistown, young man, 25 July 2004).

Some men expressed views that reflect a bias or negative attitude toward service providers. Others exhibited serious misconceptions about certain programmes, even blaming women for spreading HIV. Some felt that women’s empowerment has eroded men’s powers and concentrated most services on the needs of women. Such men view women’s empowerment as a ‘zero sum’ game whereby the power accorded to women is that taken from men. They felt emasculated at not being able to enforce discipline or control them. However, even with their limited knowledge, most women said that men could play an important role in the success of the PMTCT programme. They felt that there was a need for these programmes to target males, even if it means using innovative means to reach men, including designing specific messages for men and delivering information and education materials to places most frequented by men, such as football matches, the workplace, bars etc.

Why women are reluctant to register for PMTCT programmes

The fear of stigma and discrimination and abandonment by the partner, family and friends was revealed in the discussion groups as the main reasons why pregnant women do not register for PMTCT programmes, even after their HIV positive status is known. Some women reported that it is not easy to enrol for PMTCT because once people see you going to collect milk at the health facility, they will know you are HIV positive and may start talking badly about you or even isolating you. Because of that, most women decide to breastfeed deliberately so that people think they are HIV negative. Some women fail to register for PMTCT programmes because, after testing for HIV, the health workers do not bother to find out if they are mentally prepared or strong enough to inform their relatives (partners, mothers or next of kin). Some women decide to keep quiet and breastfeed their babies even if they have registered and followed other procedures.

Why men do not accompany their wives and partners to clinics

One of the main objectives of the present study was to explore the reasons why men do not accompany their wives or partners to the antenatal clinics or VCT or PMTCT clinics. We focused on this question, time and again, trying to elicit responses from both men and women. We found that a number of barriers exist in the community
preventing men’s participation and increased role in antenatal clinics and related services. These range from a lack of motivation; men’s bias against service providers; strong traditional stereotypes and misconceptions about the different roles of men and women in reproductive health, as well as class differences between the service providers and men. Some men felt that there was very little point in accompanying their partners to the antenatal clinics because in most public health facilities, men are not allowed in the clinic room. However, it is encouraging to note that women appear to welcome the idea of their husbands or partners accompanying them to the clinic.

I would like to see our partners allowed to go inside the consulting room with us, so that when I go for the first time, that is when I am three months pregnant, and my blood is drawn for HIV and AIDS testing, he is there to know why I need to be tested. He should start understanding from day one how a pregnant woman is treated (Francistown, young woman, 25 July 2004).

Due to the stigma attached to HIV and AIDS, some women seem comfortable accessing VCT services alone, without the physical presence of their partner, especially when the two are not married. These women felt that they could not trust men to maintain the confidentiality related to VCT, and should the relationship turn sour, their partner could gossip about their status to their friends.

It is not important because when you go with him and he finds out you are positive he can go around telling people your secret. You know how people are; if they know you are HIV positive they will haunt you about it (Masunga, young woman, 24 July 2004).

Another woman agreed with the above sentiment:

If you are not married, it is not advisable to go with your partner; men nowadays are not trustworthy, they can tell people your secret (Old Naledi, Gaborone, young woman, 14 July 2004).

In Botswana, as in most African cultures, prevailing traditional norms and expectations concerning pre- and postnatal care also tend to influence men’s behaviour. Men are usually forbidden even from seeing the nursing mother or the child for months due to strong cultural sanctions.
Breaking such a taboo is thought to bring bad luck and ill health to both the mother and the child. Most men subscribe to these societal expectations. Therefore, accompanying their partner to the clinic and being informed about everything during her consultation is seen as contrary to traditional norms and expectations.

In Setswana culture, after my wife gives birth, I am not allowed to go inside the compound. People believe that when as a man, you take your child to the clinic, they think you are bewitched. How come he is carrying a baby when the mother is there? It is natural that women should take children to the clinic. When a child is born, its father must not come near but it is funny because white men accompany their partners and nothing happens to the baby (Molepolole, a middle-aged man, 19 July 2004).

We end up blaming the nurses for not letting our partners go inside with us. However, men should be the ones who ask for permission to go inside. In 1994, when I went to deliver, I saw two white men inside the delivery room with their partners. A man can witness the delivery of his child; however a Motswana man will run away. Men are afraid of watching us give birth (Francistown, a young woman, 25 July 2004).

There was almost a unanimous feeling among men and a significant proportion of female discusants that while it is important for men to accompany their partners when they are accessing these services, men should not be required to do so on every occasion. Their argument centres on the traditional division of roles between men and women, with the men as ‘earners’ and women as caretakers of the children and family. In fact the role of men as ‘earners’ and women as ‘caregivers’ was the predominant reason why men hardly ever accompany their spouses.

There are those who want to accompany their partners and those who do not want to do so. Most of the time, life commitments restrict us, for example, when my girlfriend goes to the clinic, I can’t go because I have something important to do but when she gets back, I make sure she explains what transpired. However, women have this tendency of saying ‘everything is ok, I have been asked to encourage you to go for testing’, they never get into details with us (Old Naledi, Gaborone, young man, 14 July 2004).
Another discussant adds:

*It depends on the standard of living, men living in Old Naledi will be less likely to take their children to the clinic while those living in Phakalane' are more likely to be seen going to the clinic with their partners or children* (Old Naledi, Gaborone, elderly man, 14 July 2004).

There was consensus among men and women that if men accompanied their partners or were exposed to the same information they would acquire the knowledge and understanding. A young woman shared her frustration trying to get her boyfriend to undergo VCT after she herself had done so:

*Let me give you an example. After testing I told my partner to go for testing because I wanted him to know his status too, but he refused, saying he cannot be bossed around by nurses. We ended up having a fight about it* (Old Naledi, Gaborone, young woman, 14 July 2004).

Most men felt that the health facility set-up, especially the antenatal clinic programme, is designed to cater for women and there is no room for men. They argue that even in the event that a man accompanies his spouse, nurses only attend to the woman and have nothing to say to the man.

*I accompanied my partner once. I went with her because I had little knowledge about PMTCT and wanted to help her. I was not allowed to go into the consulting room* (Molepolole, young man, 19 July 2004).

From the study, we recognised several barriers to men’s increased role in antenatal clinics and PMTCT programmes. They are individualistic, socio-cultural, and institutional and policy related.

Individualistic barriers include:

- lack of awareness of resources available in the community
- men’s bias and suspicion/negative attitudes towards health care providers
- expectations about services that differ from programme offerings; and
- the inability to confront myths and misconceptions that inhibit men’s participation or involvement.

1 Phakalane is a posh suburban area.
The socio-cultural barriers are:
- strong misconceptions about men’s reproductive health needs
- cultural stereotypes/traditional masculine stereotypes
- class differences between service providers and men
- failure of service providers to understand the culture or the unique needs of men
- lack of community interest or motivation; and
- religious and other beliefs that reinforce traditions and customs.

There are several institutional barriers as well, such as:
- insufficient information on men’s health needs
- health care professionals who lack training to deal with men and their needs and expectations
- negative staff attitudes
- inadequate knowledge about the programme components among community or religious leaders; and
- little or no involvement of opinion leaders like chiefs, community leaders and religious leaders in motivating males.

Apart from these, there are policy barriers that include low priority in financing information and education programmes aimed exclusively at men, and weak coordination of men’s services at various levels.

**What needs to be done to encourage men to accompany their partners to the clinic**

Discussants suggested a number of measures that could be promoted to encourage men’s participation in antenatal and PMTCT programmes. These suggestions ranged from legal and coercive measures to innovative approaches.

It is high time a government stipulation is promulgated that antenatal clinic attendance should include both the woman and her husband or partner. If this is too demanding, men should be required to attend at specific critical times, such as the first visit or at given intervals.

There is a widespread feeling among men that even if they accompany their partners to the clinic, they are not allowed inside the consulting room. This has to be changed. An atmosphere should be created in the clinics where men are freely allowed to sit down with their partners during consultations and they should feel that they are welcome. Men seemed to have only some awareness but not sufficient knowledge about what antenatal clinics entail. There is a widespread perception that all antenatal clinic services offer for a pregnant woman is massaging of abdomen
by nurses. This suggests that there should be a strong information and educational component targeting males on the details of these services.

There is a feeling among men that the antenatal clinic services are the sole domain of women. This results in a lack of interest among men in these issues. Generally, women prefer to visit antenatal clinics with their spouses or partners. The crucial importance of the role and involvement of men in antenatal clinic services and related services like VCT and PMTCT should be emphasised in the information and education communication strategy, especially in rural areas.

**Conclusion and recommendations**

The main focus of this study was to explore the reasons why male involvement in antenatal clinics, VCT and PMTCT programmes is very low in Botswana, and to find ways and means to enhance it. We found that while women in general have more knowledge about antenatal clinics, VCT and PMTCT, most men are only just aware of those programmes. This is mainly due to the fact that men, by and large, do not show much interest or motivation.

At the same time, they are being excluded from antenatal clinics and PMTCT programmes by the systems, the culture and by women themselves. As a result, men fail to offer the necessary support to women, despite the expectation that they do so. Most of the health and HIV and AIDS educators are women and they also seem to be biased towards women. This may be due to them considering antenatal clinics and PMTCT to be women’s issues alone, since it is women who have to enrol. An attitudinal change is required in both society at large, and among health workers to move away from regarding antenatal clinics and PMTCT as the exclusive domains of women, and to take both women and men on board. Men should also play a role as health educators.

Based on the analysis, some policy-related recommendations are made:

- Both men and women should be targeted equally in all information and education communication activities, as well as more efficiently and effectively both in urban and rural areas. Without sufficient involvement by men, programmes like antenatal clinics, PMTCT, and VCT cannot succeed satisfactorily.

- Information and education communication activities should focus on leaders or chiefs, who could in turn be effective in motivating both men and women in rural areas to utilise HIV management services.

- There is clear evidence of the fear of stigma and discrimination associated with HIV in the community. Concerted efforts are called for in mitigating this through educational efforts in all spheres of life.
It is time government introduced regulations that stipulate the presence of husbands or partners at the time of antenatal clinic service utilisation.

There is a need for a drastic change in the attitude of antenatal clinic service providers, especially paramedics. They should ensure that accompanying men feel comfortable and important in the clinic atmosphere.

There is a need for psychological counselling at antenatal clinics, PMTCT and VCT service centres to mentally prepare the HIV positive women and men to withstand the shock and to inform their relatives (partners, mothers or next of kin).

References


Chapter 5

Couples Counselling:

A tool for promoting male involvement in HIV and AIDS management in Botswana

Poloko Nuggert Mmonadibe
Since the establishment of the HIV and AIDS programmes, there has been consistent limited participation of men in HIV and AIDS management. This is attributed to the fact that numerous policy frameworks and programme interventions directed at sexual reproductive health and HIV and AIDS have focused primarily on females. More is known about females and HIV than males and HIV (Mookodi & Maundeni, 2007). The HIV and AIDS impact survey shows that for people aged 10–64 years, there are more females (30.3 percent) who tested for HIV compared to men (19.5 percent) in 2004 (NACA, 2004). Therefore, the gender imbalance in the interventions and programmes related to HIV and AIDS and reproductive health has made the optimal management of the epidemic difficult to attain. Phaladze & Tlou (2001) point out that efforts to address the AIDS epidemic without the contribution of men are doomed. However, policy and programme frameworks are not the only factors in this matter. There are also some significant socio-cultural elements contributing to the problem.

Management of HIV and AIDS involves acquiring strategies and conduct that decrease or halt HIV transmission, that reduce the prevalence of HIV, and prevent the progression of HIV into AIDS. These include new sexual behaviours, such as abstinence, monogamy, non-penetrative sex, and the use of both female and male condoms. Emphasis is placed on couples counselling because it is gender balanced in terms of service provision. Additionally, some researchers have found that in countries with a high prevalence of HIV, like Botswana, it is fairly common for couples to have discordant (different) HIV test results. In Africa, 75 percent of couples are concordant negative, 12.5 percent discordant and the other 12.5 percent concordant positive (Dillon et al., 2005). The prevalence ranges from 3–20 percent among married and cohabiting couples in Africa (Lurie et al., 2003). The prevalence of HIV-discordance among couples in Sub-Saharan Africa is high. A large proportion of incidents of HIV infections in the region occur within married HIV-discordant couples, but few interventions currently target couples (Painter, 2001). In Botswana, the prevalence is high among people living together (cohabiting and married) at 31.5 percent (NACA, 2005).

The focus of this chapter is four-fold. It presents an overview of male HIV and AIDS interventions in health services in Botswana. It then explains how couples counselling can facilitate male involvement in the management of HIV and AIDS. The chapter calls for an intensified integration of
couples HIV and AIDS counselling in both non-governmental, private and government health care services so that men can find involvement in HIV and AIDS management. It also discusses challenges to male participation in counselling, and provides strategies to sustain men’s contribution in HIV and AIDS management. Recommendations to address some of the gaps identified in service delivery are provided.

The nature and scope of male HIV and AIDS interventions and health services in Botswana

Female-oriented reproductive health programmes outnumber male-oriented services in Botswana. The government of Botswana recognises that efforts to encourage men’s participation in sexual reproductive health have not produced significant results. Some research findings have indicated that more women are exposed to information about sexual and reproductive health than their male counterparts (NACA, 2005).

Several research projects have been undertaken in the country targeting male involvement in sexual and reproductive health, including HIV and AIDS. None of them has had a significant impact in attracting a larger number of men to actively participate in HIV and AIDS management. The government of Botswana has undertaken the following surveys: ‘The Botswana Males and Family Planning Survey’, ‘Trends in Youth Sexual Behaviour’ and ‘The Assessment of Peer Education in the Prevention of AIDS and Sexually Transmitted Diseases among Youth in Botswana’, and ‘Men, Sex and AIDS’. Other studies include ‘Gender and HIV and AIDS: male risk and male sector interventions in Botswana’ (Mookodi & Maundeni, 2007), ‘Sexual expression by the University of Botswana male students in an era of AIDS’ (Fuh, 2004), and ‘Factors influencing Botswana men regarding use of condoms as a preventive measure against AIDS’ (Kebiditswe, 1990).

Numerous HIV and AIDS programmes have been established, mainly in urban and semi-urban areas, to address the problem of lack of male involvement in HIV and AIDS activities. The non-governmental Society of Men against AIDS in Botswana (SMAABO) was established in 1993 to educate men around issues of HIV and AIDS. Some organisations, such as Total Community Mobilisation (TCM) and BOTUSA (Botswana–USA Partnership) develop strategies and programmes that address male specific needs. Other organisations and programmes, such as The Male Involvement Programme in the Ministry of Health, Peer Approach to Counselling Teenagers (PACT), Centre for Youth and Hope (CEYHO), Youth Health Organisation (YOHO), and Botswana Family Welfare Association (BOFWA) have made efforts to integrate programmes that address the needs of males, especially the youth, to enhance their
health status. BONELA and Ditshwanelo (Centre for Human Rights in Botswana) are also involved in advocating for the needs of men in Botswana. Men’s Sector Committees in various districts aim to engage men in HIV and AIDS management; their performance and sustainability has however been unsatisfactory. Tebelopele Voluntary Testing Centre exposes men to HIV and AIDS information through individual and couples counselling.

Most of these programmes and organisations’ efforts are bound to fail for various reasons. For example, some of the programmes were established without prior consultation with men. Apart from consultation problems, some of them fail because of limited resources to sustain their existence.

Despite the existence of numerous HIV and AIDS programmes, men’s needs and issues are still not given the attention they deserve, especially in rural areas. Most men who reside in rural areas do not have adequate access to programmes. This encourages both men and women to conclude that HIV is not a threat in their communities (Heckman et al., 1998). Additionally, the individualised approach and female-dominated service health sectors and provision, as opposed to family and couples-oriented approach, has contributed much to men’s reluctance to participate in HIV and AIDS programmes. The exclusion of men in sexual and reproductive health services (such as prenatal and postnatal programmes) has also misguided health services and projects, such that men tend to disassociate themselves from health care issues (UNFPA, 2004). This often results from the fact that gender relations and collective benefits are still contradicted by many messages that focus on women and exclude men from the picture. Furthermore, the preferred form of support for people living with HIV and AIDS has mostly been individual counselling and women’s support groups, with men marginally included.

Moreover, there has not been much effort towards the prevention of HIV infection among couples in the majority of health services and interventions in Botswana. This is partly due to health services in Botswana not creating an environment in which couples feel free to seek assistance together. Couples, especially unmarried ones, have not always been recognised as a unit in health care services. An example can be drawn from the method that has been used by the health system to treat Sexually Transmitted Diseases (STDs) and Sexually Transmitted Infections (STIs). The person who goes to the hospital will be given a ‘treatment document’ to give to their partner, so that the partner can get treatment. This system leaves room for those who do not present any symptoms of sexually transmitted diseases or infections to decline treatment. It creates an opportunity for the spread of these diseases and infections, and increases the vulnerability of both men and women to HIV infection.
This chapter advocates for the use of couples counselling as a tool to include men in HIV and AIDS management and to maintain gender-balanced services. Culturally sensitive strategies that can be used to motivate men to participate in couples counselling and HIV and AIDS management are also presented. Additionally, the chapter proposes that health care services should adopt a culturally specific health care model (CSCHCM) and undertake HIV and AIDS programme intervention-focused research, especially in rural areas.

**Benefits of couples counselling in the management of HIV and AIDS**

Counselling is a facilitative process in which the counsellor, working within the framework of a special helping relationship, uses specific skills to assist clients to develop self-knowledge, emotional acceptance, emotional growth and personal resources (Van Dyk, 2008:219). It can be applied in different contexts and settings. Male involvement is used as an umbrella term to encompass the multiple ways in which men relate to sexual health issues and programmes, reproductive rights and reproductive behaviour (De Bryun, 1995). Male involvement includes men’s ability to take an active role in sexual health issues with their partners and supports the choice to test for HIV with their partners as couples.

Although much has been said about male involvement in sexual and reproductive activities, a very small number of activities have been undertaken on couple-friendly or male friendly services in Sub-Saharan Africa (Baiden et al, 2005). As with other countries in this region, there has been little effort regarding primary prevention of HIV infection among couples in Botswana. Primary prevention requires couples to seek services to acquire the resources and capabilities to help them minimise the possibility of getting infected with HIV. The recognition of a couple as a unit and the need to encourage men to engage in HIV and AIDS management is imperative, because men play a role in sexual and reproductive health.

The definition of couples extends to people in pre-sexual, dating, engaged, cohabiting, polygamous and reuniting relationships. HIV and AIDS are health problems related to the physical, psychological and social risks of human sexuality, and the production and social well being of people. When fully integrated into the health services and AIDS programmes, couples counselling can directly offer men the opportunity to get involved in the management of HIV and AIDS and to effectively utilise other health services. As a primary prevention tool, couples counselling encourages couples to know their statuses before they have a child. Counselling can lead to early detection of HIV infection among cohabiting, long distance, married and reuniting couples and can allow early intervention and delay the development of AIDS (UNAIDS, 2001).
Men can also get information relating to treatment of opportunistic infections among HIV positive individuals such as antiretroviral therapy, and how to share the burden of preventing HIV and AIDS.

Without risk reduction, HIV positive partners are likely to infect their HIV negative partners and all discordant couples will become concordant positive. So, couples counselling will not only address the issue of male involvement, but will also act as a risk reduction method. The findings of some studies done in Botswana on HIV and AIDS indicate that men in Botswana have a problem linking their knowledge about HIV and AIDS issues with their sexual behaviour and the need to practice safer sex (Fuh, 2004; Selelo, 1994; Kgosidintsi & Mugabe, 1994). Therefore, couples counselling empowers men with the knowledge about HIV and AIDS and sexual relationships, and facilitates behaviour change skills.

Men can also learn other life skills that can enhance their reproductive lifestyles. With the knowledge that they acquire during counselling, they can be motivated to take part in activities and programmes that seek to curb HIV transmission. Couples counselling strengthens men’s responsibility for the outcomes of their sexual behaviours, including the need to practise safe sexual behaviours to protect themselves, their partners and families from sexually transmitted infections, HIV and AIDS. HIV counselling and testing of couples, with follow ups, has resulted in sustained increases in reported condom use from 3 percent at baseline to 80 percent after counselling and testing among discordant couples (Allen et al, 2003). Couples with limited or no information about the etiology, spread and management of HIV and AIDS can benefit from the process. Selelo (1994) and Kebiditswe (1990) have also noted that availability of direct education to men on the risks and penalties of HIV, AIDS and other sexually transmitted diseases should be regarded as a compulsory basic strategy in effective AIDS and STD prevention programmes.

It has been established that many women find it difficult to persuade their partners to adopt safe sexual practices such as the use of condoms (Akinade, 2003). Couples counselling offers partners a safe environment to discuss the importance of assuming safe sexual practices. For example, in a sexual reproductive health study in Ethiopia, it was found that where couples attend reproductive health services together, men are more likely to initiate contraceptive use than when women participate alone (UNFPA, 1995). Therefore, couples counselling is likely to encourage men to adopt safer sex behaviours.

Research findings in Botswana indicate that sexual communication is limited amongst men (Fuh, 2004). Men can benefit from couples counselling because it facilitates greater communication between partners. Couples will know their status and also learn communication and problem solving skills, heighten their self-awareness,
and ways of enhancing their sexual relationship (Kellerman et al, 2006). Couples do not usually discuss risky behaviours such as infidelity, therefore, counselling can offer men some space to discuss these issues with their partners and minimise the risks of getting infected and infecting their partners. It can encourage partners to be faithful to one another and eradicate the tendency to have multiple partners. Moreover, it motivates men to acknowledge that they are equally responsible for the management of HIV and AIDS.

During counselling, issues of cultural attitudes, ignorance, misunderstanding and misconceptions about HIV and AIDS that often hinder men from participating in HIV and AIDS programmes are addressed. Because both get to know the HIV status of the partner, it addresses issues such as the fear of being rejected by their partner if they disclose their HIV positive status. In a study done in Rwanda, almost 75 percent of the women who underwent HIV tests individually did not expect a supportive reaction from their partners after positive test results (Dillon et al, 2005). Couples counselling enhances men’s responsibility to support their partners.

Women often do not demand condom use during sexual intercourse because they fear that their partners might abuse them and accuse them of sleeping with other men (Akinade, 2003). HIV and AIDS couples counselling can also limit the occurrence of other social ills such as ‘intimate’ partner abuse. It prevents violence that usually occurs as a result of the presence of HIV and AIDS in the family. In addition to direct benefits received during counselling, male participation in couples counselling could inform efforts to improve the efficacy of male involvement in HIV and AIDS management. It can also help health service providers to develop more effective counselling protocols and male-focused support strategies to prevent HIV transmission.

**Challenges to male involvement in counselling**

Several factors can affect men’s involvement in counselling. One of these are the cultural norms that influence people to act in ways that put themselves and their partners at risk of infection and deny themselves access to health services. The culturally prescribed rules of conduct for males and females and the widely shared beliefs about the personal attributes of men and women jeopardise men’s access to counselling services. Men are culturally and socially believed to be strong. If they are seen utilising counselling services, their peers might ridicule them and label them emotionally weak.

Some men may reject counselling and view it as feminine, and label it as a programme for the ‘weaker sex’ (Baylies & Bujra, 2000). A man who goes for couples counselling may be criticised and derided by his peers for being submissive. His female
partner may be accused of putting him under some kind of spell. For example, in some Batswana tribes, men are not supposed to see their newborn babies. The attendance of a man at antenatal and postnatal clinics is usually questioned by society. Such experiences are impediments to men’s involvement in sexual reproductive health and HIV and AIDS management. Some Batswana men are reluctant to visit health centres and only go there when they are just about to die from AIDS because they have been socialised to suppress their feelings (Mookodi & Maundeni, 2007). Cultural beliefs and norms, such as those which play a role in discouraging men from accessing health services, influence their negative reactions towards counselling.

One other factor relates to the age of males. Some research findings in Botswana show a correlation between the age of the male and his attitudes towards HIV and AIDS. Older males tend to have more positive attitudes, practices and better knowledge about HIV and AIDS compared to younger males (Selelo, 1994). This implies that younger males may be more reluctant to access counselling services compared to older men. Additionally, limited information about HIV and AIDS counselling centres and the counselling process, especially in low income and rural areas, could discourage men from going to couples counselling. Information is vital to dispel various myths about sexual well being and HIV and AIDS issues. They may have some negative pre-conceived ideas about HIV and AIDS couples counselling. Further, the lack of information emphasising the need for men to take part in HIV and AIDS and sexual and reproductive health is also a barrier towards the integration of couples counselling services in the current health system. Lack of information is also linked to the time period in which services are provided (Mookodi & Maundeni, 2007). Most working men find it difficult to go for counselling because health centres and services in Botswana are only open during working hours.

Men are culturally providers, protectors and leaders (Maundeni, 2003; Akinade, 2003). Therefore, some men expect that only they may initiate changes in the relationship, and other developments in their sexual relationships. For example, if a woman decides to terminate the relationship, a man may view it as rejection; so if a woman initiates couples counselling, a man may think that the woman wants to be in control.

Three modes of decision-making can be identified to explain the degree of collaboration between a man and woman: the syncratic, autonomous and autocratic modes. The syncratic mode is a collaborative discussion on the same issues; the autonomous mode is a situation where each person makes decisions separately on issues, and the autocratic mode is where one party dictates decisions to the other (Renick et al, 1992). The autocratic mode is common in patriarchal societies. The UNFPA Report (2004) buttresses this by indicating that in patriarchal societies, like Botswana, men may fear losing control of the power and over their woman if they
discuss reproductive and other health issues with their partners. The autocratic approach to decision-making in relationships often leads to ‘intimate partner killings’. Therefore, the balance of power and violence within the relationship determines the man’s decision to go to counselling (Baiden et al, 2005).

Some men are abusive towards their partners; others are unsupportive. This may restrict women from initiating couples counselling. Some men may refuse to go to couples counselling because of the knowledge that it will empower their partners. Additionally, some women who may not want to go for counselling with their partners may make it difficult for their male partners to access counselling services. Women have been socialised to be submissive and this has made them resist leadership roles. According to Maundeni (2003), the subordination of women has put them in a tight corner where they have little control over their own life and the timing of sexual activities. They lack the power to move out of partnerships that are violent and which put them at risk of getting infected with HIV. Some women even think that it is their obligation to abide by what their male partners want: they find it difficult to negotiate with their sexual partners to go to HIV couples counselling. In Botswana, many HIV positive husbands and partners do not declare their sero-status and they are unmindful of having unprotected sex with their wives and other women (Akinade, 2003).

Moreover, some Batswana men have expressed the view that health centres and other HIV and AIDS interventions are not ‘male friendly’ (Mookodi & Maundeni, 2007). Women dominate the health services with counsellors, nurses and social workers being mostly women. As a result, men are unlikely to discuss family and sexual reproductive issues with a female. They would rather talk to a male peer or visit a male traditional doctor. In addition, if women do manage to go with their male partners for counselling, they are likely to encounter some challenges during counselling because women are more receptive than men (Djamba, 2003). For example, women are willing to listen to and consider what may transpire in the counselling sessions, whereas men may have difficulty doing that.

Health service procedures in Botswana tend to encourage and mystify the idea that men are not primarily part of the health services. Some hospital procedures and regulations discourage men from taking part in health activities that can motivate them to take an active part in issues of sexual and reproductive health, HIV and AIDS. For example, men are not allowed to fully take part in pre- and postnatal activities.

Communication between women and men can be difficult, especially regarding condom use, disclosure of risky behaviours and HIV status. A study on the cultural practices contributing to the transmission of HIV in Botswana revealed that many HIV cases among women were a result of sexual intercourse with a male partner whose HIV status was unknown or unreported. This shows that women sometimes
are unaware of their partners’ HIV status, putting them at risk. However, women may be afraid of encouraging their men to go to couples counselling because their male partners may think that it suggests that they are promiscuous or that they have HIV (Akinade, 2003). Furthermore, the refusal to go to couples counselling by women negatively influences men’s participation in counselling. For example, in a study done in Kenya on issues related to men and reproductive health, it was established that the willingness of a husband to accompany his wife to an antenatal clinic was found to be associated with the willingness of the wife to go for an HIV test (Muia et al, 2000).

Stigmatisation of people living with HIV and AIDS is still a major problem in society. It is a barrier to testing and care, and may have the same effect on couples counselling. Men are reluctant to test together with their partners because of the stigma and discrimination associated with HIV and AIDS. The results of a study done in five African countries on stigma, HIV and AIDS show that the community still views HIV and AIDS with fear since they believe that they may be exposed to rejection, isolation and social withdrawal (Uys et al, 2005; Kohi et al, 2006).

Sustaining men’s participation in HIV and AIDS management: the way forward

HIV is transmitted through individual behaviours formed within the context of cultural beliefs and values, which need to be considered when developing HIV and AIDS interventions (Baldwin & Rolf, 1996). It is through popular participation that men can claim ownership of the programmes. Therefore, a culturally specific health care model should be adopted in order to encourage men to access health services (Goicoechea, 1997). Culture is a very important factor that moulds one’s psychological and social being (Heckman et al, 1998). The knowledge of the values that shape men’s behaviour is very important, as it is through the understanding of their culture that relevant intervention programmes can be established. The initial step towards cultural sensitivity is to understand the culture of the population to be served. This requires undertaking HIV and AIDS intervention-focused research nationally in Botswana to develop appropriate HIV and AIDS intervention programmes that can change attitudes towards couples counselling and other health services. The process can help health workers to understand new ways of encouraging men to make use of health facilities and counselling centres.

Apart from research, the use of existing traditional and cultural mechanisms that specifically target men should be used as forums where men can get messages about HIV and AIDS. For example, in villages where mephato (regiments) exist, the leaders can be used as educators who encourage men to go to health facilities for couples counselling. The chiefs (dikgosi) and headmen (dikgosana) are the most respected and
significant figures in many communities in Botswana. Culturally men, especially in the rural areas, follow their chiefs: *lefoko la kgosi le agelwa mosako* means that whatever the chief says, must be done and cannot be rejected by his followers. Chiefs could be used as ‘messengers’ to break men’s resistance to accessing counselling centres. Mookodi & Maundeni (2007) have also recognised the importance of traditional leaders in the fight against HIV and AIDS. The chief can use *kgotla* meetings to educate men about the importance of couples counselling. Cultural norms and sayings that usually empower and give men confidence can be incorporated in HIV and AIDS educational messages to motivate them to participate in couples counselling. For example, the Setswana saying *Ga di ke di etelelwa pele ke manamagadi* says that females cannot lead. Such sayings should be used to motivate men to take an active role in couples counselling and the management of HIV and AIDS. Interventions can be centred on the cultural aspects that men enjoy most. In Botswana, indigenous or traditional music and contemporary music can be used to educate men on the benefits of HIV couples counselling and testing.

HIV and AIDS as a sexual health issue requires men and their partners to work together to contain HIV infection. More services that are men-friendly should be put in place to encourage them to participate in the management of the epidemic (Fuh, 2004; Maundeni, 2003; Mookodi & Maundeni, 2007; UNFPA, 1995). Men are socially and culturally not encouraged to perform caregiving duties. They are expected to spend their time generating income; therefore, counselling services should be open in the evenings and on weekends when they are not at work. Additionally, premarital HIV and AIDS counselling and testing should become compulsory in Botswana though there may be resistance in the beginning. Some people believe that marriage is a licence for unprotected sex. Culturally couples are expected to have a child after marrying to make the marriage ‘stronger’. Compulsory premarital counselling provides information about contraception, HIV, AIDS, sexual and reproductive health (Wu et al, 2005). The government and NGOs should consider training that focuses on male counsellors and health assistants. In addition, people such as bartenders, barbers, traditional doctors and sports coaches should be targeted as resource persons who can encourage men to visit health centres, especially couples counselling.

Locally produced men’s health magazines that discuss health issues and men’s concerns should be used to educate men about issues of HIV and AIDS. Men’s opinions on how the health care system of Botswana can meet their needs could be easily sourced. Men who have been to couples counselling can use the magazines to share their experiences with other men. Baldwin & Rolf (1996) have indicated that men are attracted to messages that promote positive role models, that enhance self-image and are humorous. However, Mookodi & Maundeni (2007) cautioned that male focused informational and educational communication messages should
be developed with their intended target groups. Therefore, intervention programmes and messages should correlate with the age group of men. Lastly, mobile counselling and a testing system should be introduced. This can educate men in inaccessible and remote areas such as cattle posts and settlements, about counselling, HIV and AIDS.

**Conclusion and recommendations**

This chapter advocated for the use of couple counselling as a tool to encourage male involvement in the management of HIV and AIDS. Couples counselling services can help to create a society that supports gender-balanced services. By providing gender-sensitive health services, men will have greater access to other health services.

There should be health service regulations and procedures that encourage people to access health services as couples if they are in a relationship, regardless of their marital status. HIV and AIDS enrichment programmes can be integrated into the health care system as a primary prevention strategy. For example, there can be HIV and AIDS medication adherence counselling programmes that are specifically designed for couples. Couples counselling can promote a high degree of present and future harmony so as to stimulate the psychological, emotional and social well being of couples and families (Dillon et al, 2005). Health workers should relate to couples as a unit to enhance the implementation of couples counselling and the inclusion of men in HIV and AIDS management.

Men should be trained in couples counselling so as to provide these services to other men. Furthermore, health policy and other processes that promote male participation in health issues, such as paternity leave, should be in place.

Regarding HIV testing, there should be culturally sensitive government health programmes that motivate couples to go for HIV testing together. Additionally, more studies that systematically assess the direct experiences of men living with HIV should be undertaken to help relevant stakeholders develop effective interventions for men in Botswana. Lastly NGOs, the private sector and the public service should organise more resources that motivate men to be active participants in alleviating HIV and AIDS.

**References**


Nankana district of Northern Ghana: is couple counselling the way forward? 
* AIDS Care, 17: 648–657.


Chapter 6

A Generation in Jeopardy:

Sexually active women in patriarchal cultural settings and HIV and AIDS

Rebecca Nthogo Lekoko
Every day, someone is affected by HIV and AIDS. Women and youth are the hardest hit in Botswana (CSO et al, 2005). The rising prevalence and complexity of female infection rates; of grandparents raising grandchildren; children raising children; teachers dying; teachers infecting students; the dying working class and the unborn who are infected by their pregnant mothers, are all part of the order of the day. No one can be silent about the multifaceted and astonishing nature of the HIV and AIDS epidemic, especially as it affects mostly the sexually active and future generations of Botswana. The evidence around us is that:

when so many young people die, the society loses not only these people but also their productive potential. The nation loses people who contribute to the well being of the society as a whole. As the family copes with the ill family members, their priorities are diverted. They are no longer focused on working to provide income or farming to provide food. Instead they use their time and money to care for the sick family member. Not only the present is affected, but also the future members of the family as they discontinue education because of financial needs of the family. Even burying the dead makes life more difficult for the family and the society. Funerals are often costly, increasing economic burdens on the family. People miss days from work because of the funeral rituals, a cost that affects them and their employers (Baylor International Paediatric AIDS Initiative, 2003:178).

Although Baylor is not specifically addressing the Botswana situation, the picture he paints of the world of HIV and AIDS captures succinctly what our society is experiencing. To the picture that Baylor has created, one may add many young people who are already disadvantaged by life circumstances, for example, the challenged (disabled); the street children; the uneducated, and orphans, whose exposure to HIV and AIDS becomes a double-disadvantage: as the number of AIDS orphans increases, many become homeless. Faced with the daily struggle to find food, clothing and shelter, they may be unable to attend school and as such they are at risk of sexual exploitation, abuse, discrimination and exposure to HIV infection (ibid, 2003).

The CSO et al (2005) locates the problem of HIV and AIDS both at the micro- and macro-economic levels. This indicates that not only the sexual and educational dimensions of HIV and AIDS should be considered, but also other social issues such as ‘gender inequalities, poverty, empowerment
of women and girls, income and asset equality’ (CSO et al: xviii). When these issues are considered, traditional patriarchal power cannot be ignored as one of the weapons used in Botswana to perpetuate inequalities between males and females. The chapter begins with a discussion of the conceptual framework to understand how patriarchal culture shapes attitudes towards HIV and AIDS and exposes females to the scourge. The second section explores patriarchy in marriage, sexual relationships and the sex ratio. The last part examines cultural care and heritage, and health models as sources of HIV prevention strategies.

**Patriarchal culture and jeopardy**

Patriarchy explains why some societies ‘position women as sexual objects to be overpowered in a man’s efforts to assert his masculinity’ (Kincheloe, 1999:287). In a forceful way, women are considered useful and productive only in childbirth in this cultural setting. Thus, males are accorded power to make decisions in sexual relations. The deep-rooted conviction held by some people that women are ‘not to be heard, but only to be seen’ illustrates the position of some women in sexual relationships. In these relationships, women are expected to be physically present to satisfy men’s sexual desire. A woman’s voice is not to be heard requesting a man for sexual favours. These convictions are supported by studies done in some patriarchal cultural settings (Mugalla, 2006; Kanchan, 2001; Mitsunaga et al, 2005).

Studies such as the ones mentioned above have revealed that males are the primary sexual initiators and decision-makers and females are unlikely to be assertive in negotiating for safe sexual practices such as condom use. These socially reinforced practices of oppression and subordination of women increase their vulnerability to HIV infection. Furthermore, the social tolerance of sexual networking by men has also been identified as a factor that drives the spread of HIV and AIDS in patriarchal societies. The Setswana saying *Monna selepe o a amogwana* illustrates this. Literally translated it means ‘A man is like an axe in demand, going from one (woman) to another.’ It is for this reason that the chapter presents sexually active females as women in jeopardy.

The inequalities brought about by patriarchal reasoning express themselves in a number of ways. Jeopardy is one way. When females try to exert their power to negotiate for safe sex, problems arise. Rose-Innes (2006), for example, reported that if a girl asks a boy to use a condom, she would be considered HIV positive. This way of thinking discourages some women from insisting on or even asking for safe sex. Those who are brave enough to insist on the use of condoms face severe punishment, such
as males ‘pricking the condoms as punishment for being arrogant enough to demand condom use’ (Kanchan, 2001:42). In some cases, the high prevalence of rape puts some women at risk of acquiring HIV. These forms of gender inequalities expose more women than men to HIV infection. It is, thus, not surprising to learn that statistically, the rates of infection are higher for females than for males.

In the age group of 15–19 years, the HIV and AIDS infection rate in Botswana is estimated at nine times higher for females than for males (Taylor et al, 2004). Therefore, the term jeopardy is used to describe the complexity of the patriarchal mentality when it intermingles with the risks of HIV and AIDS infection, especially for females, and more so for those who are sexually active and are of ages 15 to 49 (CSO et al, 2005:6). This chapter argues that one way out of this jeopardy is for health professionals to acknowledge that cultural orientations such as patriarchy can be barriers in the fight against HIV and AIDS. Such awareness would lead to the integration of cultural issues in prevention and curative measures.

Against the background given above, there are very good reasons to believe that applying or incorporating the Cultural Care and Heritage Consistency theories in strategies for preventing HIV transmission in the Botswana context would make a difference. The CSO et al (ibid:xix) acknowledges the persistence of gender inequalities in the fight against HIV and AIDS, and calls for strategies that would:

include protection of women’s rights and reduce their vulnerability to HIV and AIDS through elimination of all forms of discrimination against women and girls, including harmful traditional and customary practices, abuse, rape, and other forms of sexual violence and battering.

Patriarchy is one of the tools that perpetuate these gender inequalities. It works to reinforce subordination and exploitation of women in sexual relationships, hence increasing the vulnerability of these women to HIV.

The same research (CSO et al:8) states clearly the perception that ‘women are not able to make decisions about sex’. Patriarchal dominance becomes even more pervasive when it interacts with women’s poverty, unemployment, underemployment and other vulnerabilities that act in synergy to weaken these women’s resistance to unsafe sex and expose them to risks of being HIV infected.

It is, thus, argued in this chapter that patriarchal cultural orientations are indivisibly tied to the fight against the deadly HIV and AIDS in Botswana. Thus, the Cultural Care and Heritage Consistency Theories should be applied when developing preventive strategies. While the theories urge health providers to see patriarchal power as a potential barrier to females’ negotiations of safe sex, the Health Belief model provides ways through which
these women can be empowered to resist their male partners’ domination in decisions regarding sexual relationships. To use these theories is a consistent reminder that the cultural roots of patriarchy are still alive in some people’s thinking and act as barriers to using condoms as a preventative measure against HIV and AIDS.

**The patriarchal mentality and the HIV world**

Botswana has been faced with the deadly HIV and AIDS disease for a quarter of a century – a long time. The 1980s were not as troubled, as it was the beginning of the pandemic. No one knew then that it would accelerate at a rate that not only astonishes, but which also efficiently wipes out lives. Since the first diagnosed case of HIV and AIDS in 1985 in Botswana, HIV prevalence has increased dramatically, impacting on every facet of the economy (ibid). Women at reproductive age have been severely affected by HIV with a prevalence of 29.4 percent (ibid). Correspondingly, the prevalence rate for women in the age group 25–29 is 41.0 percent, while that of the age group of 30–34 is 43.7 percent, and those in the age group 35–39 is at 37.8 percent. Least affected are females aged 50 years and above with a prevalence rate of 12.9 percent (ibid:6).

Overall, the world of HIV and AIDS is marked by its tenacious and devastating effects on people, such as chaotic lifestyles of substance abuse and domestic violence; financial and mental instability; explosive attitudes and behaviours; outright scepticism about the integration of traditional and modern medicine; denial and stigmatisation; and the certainty of an unpredictable future. MacDonald (2007) sees this pandemic as a weapon of mass destruction, free from bombs and interim governments, but one that is more deadly.

In many ways, this pandemic has transformed Botswana from a renowned democratic country with a buoyant economy, to one of the hardest hit countries of Southern Africa, whose wealth will be reduced by 15–20 percent over a ten-year period (UNAIDS/World Bank, 2000). In 2000, UNAIDS warned that the diamond-rich Botswana, which at the time had a 36 percent HIV prevalence rate, would also face a rapid increase in the number of very poor and destitute households. To date, Botswana remains among the highest infected in the world, with an estimated 37.4 percent HIV prevalence reported in 2003 for pregnant women aged 15–49 years (CSO et al, 2005). The spread of HIV is accompanied by drastic decreases in economic, health and social status. For example, life expectancy for Batswana, which at one time was in the mid-60s and steadily rising, has now dwindled to the lows of the 40s (MacDonald, 2007). The situation is so bad that everyone is concerned. As more strategies are explored to
fight this pandemic, cultural orientations, especially the practice of patriarchy, should comprise a significant part of these strategies.

Patriarchal cultural thinking can give males the power to exert unfair pressure on their female partners in pursuit of unsafe sex. Culture here is seen as ‘a device for creating and limiting human choices’ and it is defined as ‘the sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals and so forth that [people] learned from families’ (Spector, 2004:9,10). Patriarchy is best defined as control by men. It not only explains the prestige accorded to men but also how this prestige is used to oppress and control women. Understanding patriarchy gives us insights into a number of gender inequalities, for example, why most world leaders are men and why some family traditions make it imperative for women to take the names of their husbands and for children to always carry their father’s last name (Rose-Innes, 2006). In a nutshell, patriarchy is a philosophy used to oppress, discriminate and exploit females.

Both national and international conventions have worked to fight female oppressive forces but the problem still persists. Looking back, one may be reminded of how Unity Dow in the early 1990s challenged some of these patriarchal oppressions. Unity Dow, a Motswana woman married to an American man, successfully challenged the legitimacy of the Citizenship Act which denied her children Botswana citizenship on the basis that her husband was a foreigner, even though she herself was a citizen of Botswana. The law conveyed on a foreign woman marrying a Motswana husband the right to apply for citizenship after two-and-a-half years of residence. This right was not conferred on a foreign man who marries a Motswana wife. Dow’s case challenged the discrimination in the law. She stated at the time:

_I am desirous of being afforded the same protection of law as a male Botswana citizen and in this regard I am desirous that my children be accorded with Botswana citizenship and that my spouse be in a position to make application for Botswana citizenship, should he so wish as provided for under Section 13 of the said Citizenship Act_ (Dow, 1995).

Males with patriarchal power accuse females who are conscious of these injustices as ‘destroying the family unit and subverting intimate relationships with men’ (Kincheloe, 1999:285). Females who stand up for their rights, for example, the Emang Basadi group (Stand-up Women! – literal translation) are often met with sneering and labelled ‘cheeky-girls’, ‘troublemakers’, ‘frustrated women’ etc (Ntseane & Youngman, 2002). Some males continue to resist seeing females as their equal counterparts. A professional health care system that is culturally sensitive, appropriate and competent is needed to give appropriate advice, knowledge, skills and attitudes to females in
patriarchal cultural settings that can help them fight the pressure to engage in unsafe sex. Such professional health education can counteract what Kincheloe (1999) calls ‘social death’ on the part of the affected women. This entails the loss of dignity and self-worth and the loss of hope for any way out of the grip of this patriarchal power.

It may seem odd to think that a male condom is only used when a male wants to use it but in patriarchal cultural settings this makes sense. If, for example, a man wants to protect himself, he will use it without fail, for example, when he does not want to have a child outside wedlock, he will consistently use it. These males are presented as the ‘strong’, the ‘brave’ and the ‘tough’. As a result, some of them want to live up to this patriarchal image and oppress females in a number of ways as reflected below.

**Patriarchal power in marriage, sexual relationships and the sex ratio**

Marriage is a duty, a requirement of traditional African society for a man and woman to contribute to the seeds of life, the children (Mbiti, 1988). Traditionally, marriage exists because there is fertility. Thus, in an African sense, sex has both biological and social uses. By means of its social function, sex (the results of which are children) plays a critical role in building a strong family. Sex is thus necessary to maintain a healthy family. Where this traditional view is misinterpreted or abused, it gives husbands license to be sexually aggressive with their wives. Sex on demand, for them, is part of the marriage ‘deal’. Sexual violence is a sign of passion and affection, especially where a woman resists due to fear of engaging in unprotected sex (Rose-Innes, 2006).

In a patriarchal setting, where power is extremely skewed as a result of cultural beliefs, females are disempowered and therefore cannot negotiate safe sex. As Rose-Innes observes, this unequal power relationship increases women’s vulnerability to HIV infection and accelerates the epidemic. While Rose-Innes notes that childbearing and satisfying husbands sexually and otherwise are key expectations for a wife (even if she is aware that her husband is unfaithful), the husband has an obligation to ensure safe sex. However, due to fear of stigmatisation, a partner may be reluctant to adopt behaviour that might signal their HIV-positive status to the other, for example, a married HIV-positive man may not use a condom with his wife (ibid, 2006). Some studies (Mugalla, 2006; Kanchan, 2001) indicate that regardless of the HIV status of a man, refusing a husband sex can result in rejection and violence towards the wife. A married woman who requests safer sex may be suspected of having extra-marital affairs or of accusing her husband of being unfaithful. This may spark violence from the husband.

Despite the alarming rate of HIV infections, some females still engage in unprotected heterosexual encounters for a number of reasons, one of which is economic. Rose-Innes (2006) cites the daily struggle for survival as a strong urge that can override any concerns
about getting HIV. In patriarchal settings, females are at a higher risk for a number of reasons. As Braimoh et al (2004) contend, the act of prejudice against women in areas such as inheritance rights, division of labour, access to education, political and economic resources, legal, employment and leadership matters has led to economic favouring of men. In a study with Zimbabwean adolescents, Kanchan (2001) found that poorer girls tend to have sex with older men for money. Baylor (2003) also describes the fate of poor teenagers who are pressured into sexual relationships with older men who may be infected with HIV. Many females are economically dependent on males and as such they are unable to negotiate safe sex practices such as condom use (Mugalla, 2006).

Economic power is usually expressed through decision-making dominance. Pulerwitz et al (2002) define decision-making dominance as the ability to engage in behaviours against a partner’s wishes or the control of a partner’s actions on the basis of her dependence as determined by the amount of valued resources she owns. Thus, females who are economically inferior to their male partners may have limited ability to control sexual encounters and negotiate the use of condoms for the prevention of HIV and AIDS. Rose-Innes (2006) reiterates the point that many women who lack economic power feel they cannot risk losing their partners who are sources of financial support by denying them sex, even in situations where they expose themselves to risks of being HIV infected.

Furthermore, in Botswana where females constitute 52.8 percent of the population as compared with 47.2 percent males (CSO et al, 2005), sex ratio theory may apply. As Mugalla (2006) explains, the tenets of this theory are that members of the sex that is in short supply are less dependent on their partners because a greater number of alternative relationships are available to them. This implies that in a relationship, a male may not feel obliged to stay with a female whose demand to use the condom for the prevention of HIV is not welcome, because he can look for an alternative relationship elsewhere. This raises the possibility that some males in Botswana may lack total commitment to their sexual relationships, knowing that they have alternatives (South, 1988). The sex ratio theory postulates that members in oversupply are in a dependent position and so will do and use whatever they have to keep their male partners. This skewed power is evidenced in the practices of patriarchy, polygamy or other forms of extramarital sex (Mugalla, 2006; Mitsunaga et al, 2005).

**Applying cultural care and heritage consistency theories in HIV prevention strategies**

Culture is a large part of what determines the use of condoms as preventive measures against the HIV and AIDS pandemic (Mugalla, 2006). Where partners believe that to have a strong sexual relationship is to engage in ‘flesh-to-flesh’ sex, they will refuse to use a condom, and engage in unsafe sex. Rose-Innes (2006), for example, says men
in Southern Africa regularly do not want to use condoms, because ‘flesh-to-flesh’ sex is equated with masculinity and is necessary for male health. The use of condoms too is strongly associated with unfaithfulness, lack of trust and love. This belief has succeeding in taming some females and making them agree to ‘flesh-to-flesh’ sex even at the expense of exposure to HIV and AIDS infection. This is a lamentable state for women, because when they get infected they die, while the culture remains. However, health educators cannot force people to use condoms when this is against their cultural beliefs. The best they can do is to understand their position and work from this position. The Cultural Care and Heritage Consistency Theories offer some suggestions, presented below, of what professional health providers can do to understand the culture of their target groups.

Exploring cultural competence, appropriateness and sensitivity to HIV issues

First, health providers should recognise barriers for females to negotiate safe sex with their male partners in situations where patriarchy is observed. In one way or the other, this culture contributes to the spread of AIDS (Kanchan, 2001; Mugalla, 2006). The concept of cultural competence addresses the need for health providers to understand and respond effectively to cultural issues that may act as barriers to using the male condom. Hopefully, approaching issues of preventative measures from a cultural competence perspective will enable health educators to help females transcend the domination and exploitation exerted on them by their male partners. Spector (2004:8) succinctly captures cultural competence as the ability of health providers to ‘understand and attend to the total context of the patient’s situation – it is a complex combination of knowledge, attitudes and skills’.

Cultural appropriateness is the other construct of the Cultural Care and Heritage Consistency theories. Cultural appropriateness speaks to the importance of helping females to understand that their situation (being poor, being in oversupply, etc) makes them succumb to males’ pressure to engage in unsafe sex. Understanding this will help them to develop a sense of purpose in the fight against HIV and AIDS. They need to construct a positive identity and cultivate a strong self-worth to resist risky situations. As Spector (2004) sums it up, cultural appropriateness implies that the health provider applies the underlying background knowledge of the people to provide the best possible health care. Therefore, when health professionals make an effort to understand the culture of the patients they are dealing with, they are said to be culturally sensitive. Spector (ibid:8) says, to be culturally sensitive:
...implies that the provider possesses some basic knowledge of, and constructive attitudes towards, the health traditions observed among the diverse cultural groups found in a setting in which they are practicing.

Being culturally sensitive requires health providers to assess, interpret and take into consideration a given patient’s health beliefs and practices and cultural needs. In a nutshell, a professional health education that is culturally sensitive, culturally appropriate and culturally competent is needed in Botswana in order to address the impact of patriarchy in the fight against HIV and AIDS. Spector postulates that when there is a very dense cultural barrier, the response to health care services may be compromised.

**Culture cultivates, HIV/AIDS kills: Balancing the two using the Health Belief Model**

Culture provides expected conduct but does not protect from HIV and AIDS. For example, the importance placed on fertility in patriarchal marriage settings in Botswana and elsewhere may expose people to the serious danger of unprotected sex and HIV and AIDS. To Rose-Innes (2006), patriarchal thinking, which views fathering many children as a sign of virile masculinity, may hinder males from seeing the danger of refusing to use condoms as preventive measures against HIV and AIDS. She further contends that the importance of fertility is so strong that it can pressure young females who want to prove their fertility by falling pregnant, not to use a condom (that is, prior to marriage).

Furthermore, Rose-Innes (ibid), Mugalla (2006) and Kanchan (2001) point to the practice of ‘dry sex’ as one method of exposing women to HIV and AIDS infection. Dry sex is a practice where women use traditional herbs to make their vagina small and dry believing that their male partners derive pleasure from this experience. This exposes them to a high risk of contracting HIV because this dryness may cause abrasions to the lining of the vagina.

One may also think about other cultural orientations such as polygamy, which is practiced in some parts of southern Africa, Botswana included. Polygamy – having more than one wife – is condoned by the widespread belief that males are biologically programmed to need and have sex with more than one woman. Rose-Innes has also observed that even where traditional polygamy is no longer the norm, men tend to have more sexual partners and to use the services of sex workers. These practices expose both females and males to the risks of getting HIV and AIDS. Perhaps the Health Belief Model can be applied in this situation, that is, when patriarchal thinking seems to be strong, factors such as the perceived susceptibility, perceived severity and perceived benefits can be brought in to mitigate its strength.
Understanding the Health Belief Model in HIV and AIDS issues

The Cultural Care and Heritage Consistency Theories remind us that health providers do not operate in a cultural vacuum; that they function within complex nuances of cultures that shape attitudes, behaviours and understanding towards health care. It has been stated, for example, that people who believe in and act out patriarchy respond in a certain way to health education on the use of male condoms as a method of preventing HIV and AIDS. This is especially true in situations where the use of condoms conflicts with their perceptions of sexual enjoyment, of sex as fertility, and their view of women as sexual objects. To avoid using condoms, such people will make excuses arising from their beliefs, such as that ‘condoms have microscopic holes that facilitate the transfer of the virus’ (Mupela & Fetters, 1998 cited in Kanchan, 2001); having ‘flesh-to-flesh’ sex is a sign of masculinity and a necessary cure for male health (Rose-Innes, 2006); fathering is a sign of virile masculinity (ibid); and marriage is for procreation (Mugalla, 2006; Kanchan, 2001). This type of mind-set is not easily changed.

The Health Belief Model is a psychological model that attempts to explain and predict health behaviours. Certain factors propounded by this model claim to lessen or end some of these cultural orientations that stand in the way of fighting the HIV and AIDS pandemic. Although there are at least five factors discussed in the literature relating to the model, this chapter deals with only three – perceived susceptibility, perceived seriousness, and perceived benefits as strong mitigating factors.

Regarding perceived susceptibility, there is reason to believe that people who have been deeply affected emotionally and otherwise by the destruction of life as a result of HIV and AIDS, are likely to be assertive in suggesting the use of a condom as a preventative measure, especially when they believe they are personally susceptible to acquiring HIV. A sense of susceptibility is achieved through different means. The saying that ‘experience is the best teacher’ captures one way in which people who have lost someone close or have seen the suffering of close relatives or friends due to this pandemic will resist being forced into having unprotected sex. A woman who believes having unprotected sex may expose her to the risk of getting HIV, will develop the power and the strength to resist unprotected sex. As Spector (2004:57) says:

*One of the important determinants is whether or not a person believes that the problem could happen to him or her, if he or she thinks he or she cannot get a particular disease, he or she often will NOT take action to prevent it.*

This orientation is referred to as ‘perceived susceptibility’ in the Health Belief Model. In patriarchal settings, both males and females who believe they are at risk of
acquiring HIV if they do not use a condom will speak out strongly against any sexual practice that exposes them to the risk of being infected.

Additionally, the perception of the seriousness of the destructive nature of HIV and AIDS has the potential to lead people to engage in safe sex. Spector (2004), for example, explains it in this manner: ‘…if people do NOT think that a problem or disease is serious or annoying, they may not take action to prevent it’. He further explains that the perception of the degree of a problem’s seriousness varies from one person to another and is highly related to the amount of difficulty the person believes the condition will cause. For some people, just hearing mention of the name HIV and AIDS or thinking about it, makes them fearful; they will take care to avoid being infected. Such a woman who is being pressured by her male partner into having unsafe sex, would resist. Perceived seriousness, as an aspect of the Health Belief Model, is a strong mitigating factor of patriarchal mentality. To equate the ‘flesh-to-flesh’ sexual encounter with masculinity, and view it as an expression of love and faithfulness is intolerable when considering the harmful nature of HIV and AIDS.

In life, our actions are also driven by the perceived benefits we expect to get from them. When, for example, people decide to use a condom as a preventative measure against infection, they do so knowing that not being infected is a gift of life that any one would like. The expected outcome is greater than the satisfaction that the person thinks he or she will get from engaging in unprotected sex. Being HIV infected is a situation that is much more difficult and complex to deal with, than refusing advances to engage in unsafe sex.

In a nutshell, the Health Belief model provides hope that the roots of patriarchal mentality can be uprooted by factors such as the perceived susceptibility to HIV and AIDS; the perceived seriousness of the pandemic; and the perceived benefits of following professional health care advice. This model makes it possible, and also legitimates health education by taking into consideration the background and experiences of the beneficiaries.

Conclusion and recommendations

Empowering the sexually active generation to be assertive and to resist the temptation to engage in unsafe sex is a worthy goal in the HIV and AIDS world. To appreciate the significance of the Health Belief Model in achieving this goal, one needs to know the number of deaths from AIDS, and one needs evidence of those living with the virus. Botswana has a high infection rate: three out of every five adults – making it beyond question that every person in Botswana is affected.

Who among the sexually active generation cannot relate to the pain of learning their positive HIV status? The sight of people dying, depressed, stigmatised and humiliated
should send a strong signal about the negative consequences of having unprotected sex, and promote significant changes in our thinking, attitudes and behaviours. We need to reflect on Senge’s (1990:3) contention that ‘our actions create the problems we experience.’ Consequently, when males decide to go ‘flesh-to-flesh’ as a way of demonstrating their masculinity and as a test of faithfulness, trust and love, they have to understand that their actions expose them to the risk of being HIV infected.

Trends in the fight against the pandemic indicate a highly skewed pattern of infection. Women are more affected than men. Certainly, when strategies to fight and win against this pandemic are developed, this skewed pattern has to be considered. There is a need, therefore, to build resistance to HIV and AIDS of sexually active females. This can be done at the level of the individual, the family and the community – all critical drivers for behavioural change that can contribute to the reversal of current numbers of HIV and AIDS infections and deaths. A model of health education that starts with empowerment lessons for females may help them understand how patriarchal power works to oppress and expose them to the risk of being infected.

Using real situations of women who are compromised and oppressed, that is, discussing the lived experiences of women who suffer under patriarchal power, may help females to understand their situation as ‘people who have been disadvantaged by being born women in a patriarchal Botswana society’ (Lekoko & Garegae, 2004) and to fight against the grip of oppression. Kincheloe (1999:260) describes this as helping to ‘pull oneself up by the bootstraps’. Health educators can expose women to the dangers of compromising their safety by engaging in unsafe sex. Both females and males should be made to understand the dangers of adhering to some cultural practices in the world engulfed by the HIV and AIDS pandemic.

References
Kanchan, R. 2001. Boys think you are HIV positive if you ask them to use a condom: addressing the reproductive health needs of orphans and vulnerable adolescents in Zambia. (Masters Thesis, Rollins School of Public Health, Emory University).


Mugalla, C.I. 2006. Power, Self-efficacy, and Condom Use in the Era of HIV/AIDS: The Case of Zimbabwe Female Young Adults. Atlanta, Georgia. The Rollins School of Public Health, Emory University. (Masters thesis.)


Chapter 7

Male involvement in the Prevention of Intimate Femicide in Botswana:

Issues and challenges

Diana Letlhogonolo Kgwatalala
The nation of Botswana is in shock at the violence that men perpetrate on women. Batswana males are attacking and killing their partners at an alarming rate. According to Phuthego, quoted by Chwaane (2006), in 2003 there were 54 cases of passion killings and in 2004 there were 56 cases. In 2005 the number soared to 85, and in 2006 between January and September, 44 cases of passion killings were reported.

These incidents have drawn much needed attention to the issue of domestic violence in Botswana and the many faces it adopts. The killings have come as a rude reminder of how women are daily subjected to violence within relationships that are supposed to offer them love and protection. Passion killing (as the murders are called in Botswana) has taken gender-mainstreaming efforts in Botswana a few steps back, as many women are now fearful, cautious and suspicious because they know that any sign of exercising autonomy on their side might turn out to be their death warrant.

Passion killing is not a new phenomenon. What may be unique is the frequency and gruesomeness of the murders in recent times. Their brutality when narrated may sound like a scene from a horror or sadistic movie that makes your skin crawl, and yet these are real life experiences of very ordinary men and women in society. Yet intimate femicide as a form of violence has received little attention in research, practice and policy not only in Botswana, but across the world. The few existing studies originate from developed countries.¹

Scholars define femicide differently, but all definitions have in common the killing of women by their intimate partners. Radford & Russel (1992) indicate that femicide is the extreme end of a continuum of anti-female terror that includes a wide variety of verbal and physical abuse. They further note that femicide is not a one-off act of violence; it is usually preceded by a culture of violence and control in the relationship.

In the context of Botswana, the terms ‘passion’ and ‘murder’ have become so closely related that they are now in danger of becoming synonymous.

¹ While in Botswana the murders are called passion killings, in other countries (such as the USA, Canada, India, Greece, Bangladesh, Australia, Kenya and South Africa) the murders are called horror killings, crimes of passion, horror suicide, homicide-suicide, heat of passion crimes, intimate partner homicide and femicide.
The implication therefore is that the term ‘passion killing’ tends to denote that the murders occur ‘out of love’. Nwokoro (2005) argues that there is nothing passionate about killing one’s partner, except to romanticise a purely criminal and unacceptable act. Dingake (2006) qualifies this view by noting that the murders have nothing to do with love, if passion is synonymous with love, and love is the opposite of hate.

In Botswana, most perpetrators hang themselves after committing murder. The majority of these murderers are found hanging from the rafters of their houses or in trees not far from where they committed the crime. Passion killing is one of the few crimes that results in the offenders taking their own lives following the act of murder, which makes it impossible to prosecute the perpetrators, let alone get answers about why they killed their partners. The fact that both the perpetrator and the victim go to the grave with their story and its answers is a sad ending to a love gone wrong.

The purpose of this chapter is five-fold. First it discusses factors that contribute to the occurrence of femicide in Botswana. Secondly, it explores how men’s involvement can help in the prevention of passion killings. Third, it highlights existing efforts to improve male involvement in the prevention of passion killings in Botswana. Fourth, it examines challenges to male involvement in the prevention of passion killings, and lastly recommendations that could curb the problem of passion killings are discussed.

Factors that contribute to the occurrence of passion killings

Research in the area of passion killings in Botswana is in its infancy. Therefore this section relies on the scanty literature on the issue in Botswana, as well as that from other countries. Passion killing cannot be discussed in isolation from domestic violence. The causes of passion killings are diverse and multifaceted. However, for the purpose of this chapter, the focus will be on the following: stress; psychological factors; cultural factors; women’s empowerment; extra-marital affairs; weak social bonds, and drugs and alcohol abuse.

Stress and related anger

Life, in general, has become stressful and challenging, with individuals employing different coping mechanisms (Alao et al, 2005). Stress and related anger that could influence a man to commit femicide may stem from numerous circumstances. These include the female partner’s intention to end the relationship, the perpetrator’s view that the female partner has financially exploited him (McDonald & Smith, 2004), and
feelings of betrayal due to the partner’s engagement in extra-marital affairs. Such stressful experiences are often exacerbated by the lack of support or weak social bonds that are prevalent in contemporary societies – Botswana included. The disruptive effects of industrialisation, urbanisation and migration have weakened primary group ties (such as families, churches and social clubs) within communities and reduced constraints on non-conformity among community members (Kooijman, 1978).

**Psychological factors**

Some scholars associate femicide with psychological factors. They contend that men’s personality and psychological problems influence them to behave violently (Dutton, 1998 in Gondolf, 2002). The violence is more an outburst of emotional pain, frustration or confusion. The underlying issues may stem from early childhood rearing that led to fears of intimacy or an over-attachment to women. Some men simply ‘explode’ or ‘snap’ but most appear to be dealing with inflated expectations, and so feel violated and offended when they do not get their way in the relationships they are in.

**Cultural factors**

Wingood and DiClemente (2000) indicate that a majority of men tend to define a woman not in relation to herself but in relation to them. Behaviour (1949) quoted by Wingood and DiClemente (ibid) expresses the view that in most cultures men are perceived as ‘real’ and everything else, including a woman, is perceived as ‘other’. The consequence of ‘otherizing’ women is that they become defined in terms of their similarity or dissimilarity to men. Women also become defined in terms of their functional significance to men rather than in terms of their own significance.

Such cultural definitions of a woman have socialised women into being dependent on the men in their lives, and this dependency on men has, with time, increased women’s vulnerability to all forms of male control. Passion killings, which find their roots in cultural beliefs and practices, act as a form of social control on women. They limit women’s autonomy, safety and freedom of choice as to whether to stay or walk out of a relationship they feel is dysfunctional or does not meet their needs. Dingake (2006) notes that these killings are without question sexist in nature since invariably they are committed by men and the victims are females. He also notes that passion killings are a result of the developing culture of gender equality in Botswana and that the pattern of the killings reflects a blatant tendency of machismo and chauvinism.

**Women’s empowerment**

Some researchers have associated passion killings with women’s empowerment. Botswana has made great strides in improving the status of women in the economic,
political and educational arenas. Some of the achievements include the amendment of numerous laws and policies to make them gender sensitive. For example, the abolition of marital power among couples married in community of property; the formulation of a Domestic Violence Bill; as well as the amendment of the Deeds Registry Act to allow wives married in community of property to register immovable property in their own names. Prior to the amendment, such property could only be registered in their husband’s name. These amendments met with much resistance from a majority of men in the country.

Many men feel threatened by the concept of women empowerment. They see it as a challenge to their masculinity. Fragoso (2002) supports this view, noting that as more women are being empowered by getting jobs, being financially independent and succeeding professionally, violence by men is increasing, even though it may not be directed at those who are being empowered. The WAD (1999:17) qualifies this view by indicating that due to societal changes, men are reacting violently to the loss of power and control over women, both in the household and in the work situation.

Drugs and alcohol abuse
The abuse of drugs and alcohol has been noted as one of the factors that fan violence in relationships. Alcohol is one of the major triggers of violence against women in relationships. Data from the Lobatse High Court shows that alcohol featured in 59.1 percent of the femicide cases (WAD, 1999). A study by Campbell et al (2003) also found that the abuse of drugs significantly increases the risk of intimate partner femicide.

Influence of the media
The media as a powerful tool that can influence public opinion on any particular issue has often been blamed for breeding all forms of violence. The media portrays men as aggressive, strong, independent and violent, while females are mainly valued for their appearance (with extremely narrow definitions of beauty), their (hetero)sexuality, and their passivity. The website Toolkit for Preventing Violence Against Women (2001) observes that in advertising, women’s bodies are used as objects to sell products, men and boys are portrayed in aggressive ways, and depictions of physical and sexual violence are glorified. Even implied acts of violence may support the ‘normalisation’ or sense of inevitability of violence against women. When these stories are internalised and interact in real life relationships, the result is a dominant, aggressive man paired with a woman who believes she should look pretty and keep her opinions to herself.

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2 The abolition of marital power means, among other things, that husbands are no longer considered the head of the family; both wives and husbands head the family on an equal basis.
(Media Education Foundation, 2003). It also promotes the dangerous dynamics that are common in violent relationships.

In addition, movies and entertainment television have long exploited crimes such as sexual assault, dating and domestic violence, and stalking. Often, the violence is sexualised. Some companies use violent images in their advertising campaigns for shock and aesthetic value to help sell their products. When people see these images regularly without serious commentary, they become desensitised to them (Media Education Foundation). News coverage of violence against women has often been sensational, exploitative, and lacking in serious analysis of the prevalence, cost, and underlying causes of such violence.

In Botswana, the print media has been accused of sensationalising cases of passion killing in order to increase sales of their newspapers. These stories are splashed on the front page, sometimes with pictures from the scene of the crime. Fingers have been pointed at this kind of publicity for encouraging perpetrators to want to be more creative and devious. Perpetrators of passion killings are getting bolder. On two occasions in Francistown, women were stabbed at the police station, after being followed there by their partner. Stories reporting domestic violence murders often reinforce myths and inaccuracies about domestic violence by implying victim-blaming or perpetrator excusing attitudes, blaming the act on cultural or class differences, and reinforcing the idea that the fatal violence came out of the blue, as opposed to being the culmination of a history of violence and controlling behaviours (Washington State Coalition Against Domestic Violence, 2002).

Can male involvement help in the prevention of passion killings?

This section argues that male involvement can go a long way to curbing the incidents of passion killings. Through participation in sexual reproductive health and prevention of domestic violence programmes, men and boys will feel a sense of ‘ownership’ of the problem and will have a personal relationship to the issue, as well as a stake in the process of change (Kaufman, 2001). Such feelings, in turn, will translate into unlocking resources that can be used to end domestic violence.

The potential benefits of men’s involvement in sexual reproductive health and prevention of domestic violence include expanded rights for women; improved family health; better communication between partners, and joint and informed decision-making within households (Walston, 2005). Men’s involvement will not only have a positive impact on the reduction of violence, but will also have a positive impact on a number of issues that currently affect both men and women (including boys and girls) in negative ways. The active participation of males in conceiving, developing and delivering anti-
violence efforts through direct involvement will also help find the language, approaches and techniques that will actually reach and change the behaviour of males.

**Existing efforts to improve male involvement**

For a long time in Botswana, females have been the centre of attraction when it comes to interventions and programmes that deal with domestic violence. Several programmes exist for female survivors of domestic violence, while there are almost no programmes that focus solely on male survivors of domestic violence. Programmes that focus on females provide counselling, advocacy and legal aid as well as shelter. Kagisano Women’s Shelter, Women Against Rape (WAR) and Emang Basadi provide these services in Botswana.

There are relatively few services for men. This is mainly due to the assumption that men are not physically abused by women, and are the perpetrators of abuse. If a man indicates that his partner is abusing him, the reaction from the public has tended to be that he is a ‘chicken’ because he is tolerating abuse by a woman. Even when the case is reported to the police, it is taken lightly.

It is worth noting that in the past few years, the government of Botswana and the UNPF have embarked on a joint partnership to set up the Male Involvement Section in the MoH. The section aims to increase male involvement and participation in sexual and reproductive health matters and contribute to the reduction in the spread of HIV and AIDS, other sexually transmitted diseases and prevent gender-based violence. Since its inception, the Male Involvement Section has spearheaded several projects to facilitate male involvement in sexual reproductive health and gender-based violence. One of them is the formulation of the national strategy and programme of action for male involvement in sexual and reproductive health and rights, and the prevention of HIV and AIDS and gender-based violence. If successfully implemented, this strategy can go a long way to improving male involvement in the prevention of passion killings.

One other effort that is worth noting is that the police have reformed their approach to the problem of domestic violence. This is evident by their recognition of the threat to kill as a crime. In addition, the police have shown a willingness to initiate plans to change the curricula in the Police Training College to make it more gender sensitive (WAD, 1999).

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3 The strategy was developed in collaboration with government ministries and departments, and civil society and development partners.
Challenges to male involvement in the prevention of passion killings

Although male involvement can assist in reducing the incidents of passion killings, there are several challenges that hinder the effective involvement of males. Some women’s NGOs have, in recent years, opened up their doors to provide services to males, but many men do not come forward because they associate these NGOs with divorced women, women who are married to white men, or those who are highly educated. They also believe that such organisations exist to break up marriages and confuse traditional marriage.

These views are not just held by men but also by some women, especially in rural areas. Women’s NGOs are also faced with a lack of sufficient funds to implement their programmes. The problem of the shortage of funds has been exacerbated by the withdrawal of several international donor agencies, who have indicated that compared to other African countries, Botswana can afford to fund such projects. Therefore, although some organisations realise the importance of involving men in the prevention of domestic violence, their budgets are already stretched to do so.

The other challenge affecting service delivery is withdrawal of complaints by abused women. Assistant Commissioner of Police, Mr Letsholo as quoted by Shabani (2007), said that in 2005 and 2006 33,594 cases of abuse were withdrawn by women. The cases – including offences such as rape, defilement, common assault, threat to kill, and unlawful wounding – were withdrawn after registration with the police or before going to court. Letsholo commented that by withdrawing cases, women were making it difficult for the police and the judiciary to prevent domestic violence.

One other challenge is societal resistance to changing the way males are socialised (Maundeni, 2002). By and large, males are socialised to engage in non-caregiving activities. Male involvement in caregiving activities such as cooking, washing, taking care of young children and sick people can go a long way in giving males an understanding of the value of patience and perseverance when faced with life challenges. Men may then respond better to stressful situations, such as when partners threaten to leave them. However, many people in Botswana are still resistant to changing the way males are socialised.

Conclusion and recommendations

By recognising that men can also feel powerless, a platform needs to be offered for men to reflect on their behaviour towards those they feel they have power over. On another note, Lundgren (2000) cautions that the approach of emphasising men alone, just as if women only are focused on, is inadequate since it may reinforce the status quo in gender inequalities. In recognition of the reality that autonomy, power assertion, and
decision-making lies at the heart of violence in relationships, there is a need to actively promote non-violent relationships by bringing harmony among the three aspects.

Many people understand what a violent relationship is; therefore it is time more emphasis is placed on what constitutes a non-violent relationship. By promoting healthy non-violent relationships, couples seek ways to establish and build trust; share thoughts; ideas and feelings; respect each other’s thoughts, ideas and feelings; encourage and support each other to grow; permit each person to feel loved and valued; ensure that each person feels safe to express disagreement and negative feelings including anger, disappointment and frustration, and ensure that the other person feels safe when the partner expresses disagreement and negative feelings (Wolfe et al, 1997). This is necessitated by the fact that in Botswana, boys and men are taught to bottle up their feeling and not show emotions, while women and girls on the other hand are taught to be submissive and docile. For both men and women, there is no room to express feelings and to learn that in relationships there can be equal power sharing.

In addition, all stakeholders (women’s NGOs, the Men’s Sector, government and other social welfare practitioners) should continuously question their own practices and actions regarding how they contribute to the occurrence of passion killings, and what they could do to prevent it.

Messages about domestic violence being sent out to the public (whether subtly or openly) should be assessed to see how men and women perceive what they are receiving. Information dissemination is also crucial because it increases knowledge and provides a platform for a change of attitude about domestic violence, through activities such as group discussions and media campaigns; workshops; question and answer sessions and the use of drama and songs.

For both men and women (including boys and girls) activities can focus on the correlation between the culture of patriarchy, social norms, the cultural definition of masculinity and how they oppress both men and women. Such informational materials can be made available in offices; schools; community centres, or waiting rooms in public offices and through the use of mass media and billboards. Seminars and workshops on various issues related to gender relations can be hosted countrywide (including in remote areas). The goal is to encourage information sharing and to enable people to review their own values, lifestyles and practices. This will empower individuals to adapt their current lifestyles to be more effective and healthier.

There is also a need to conduct a proper gender analysis in the context of Botswana to ensure that initiatives and programmes are based on facts and analysis rather than assumptions. This will also pave the way for gender inclusive programmes of a high quality and effectiveness.
Men should be encouraged to use counselling services and learn to communicate their feelings without using violence in any form. The establishment of marriage and relationship counselling centres is crucial. The centres should offer pre- and postmarital counselling to both men and women, without any bias. In life, human beings are taught how to get ready for the world of work, but no one offers courses on how to establish a good relationship or marriage, where both partners feel loved, respected and free to express themselves without fear of violence or intimidation.

At community level (with the involvement of the community), programmes that give adolescent boys the chance to explore their options need to be established. The involvement of community members serves a critical role because at this age, young boys need role models. These programmes also serve the purpose of exposing young men to an alternative lifestyle, and can provide them with the chance to reflect on the potential negative implications and costs of the traditional views of manhood to themselves and women.

In so doing, boys will be informed about alternative attitudes and behaviours while presenting them with different ways of conducting themselves. Programmes should include life skills such as communication skills; self-awareness and self-esteem; values identification; gender awareness and equality; the world of work; interpersonal relationships; puberty and reproduction; healthy marriages, and relationships and human rights (adopted from Johns Hopkins Bloomberg School of Public Health, 2003). Attention should be shifted towards changing the attitudes and practices of men by giving them alternatives that are more appealing and less threatening to them.

The media as a powerful agent of socialisation can be used to disseminate information in the form of messages that are geared at attitude change for men. The media should take a more active role in educating males about violence against women. It should transmit alternative messages of non-violence, to change the existing culture of violence in relationships. The Pan American Health Organization (2000) notes that this could be achieved through lobbying governments, television and radio networks, manufacturers and magazines to make their products less violent. In Botswana, the print media should be encouraged to avoid sensationalising incidents of passion killing and providing more analysis in order to avoid blaming survivors.

In conclusion, plans and programmes that leave males out of any gender equation, including both domestic violence and sexual reproductive health, are bound to be unsuccessful because assuming that programmes can successfully improve the lives of women and girls without addressing and involving men is failing to acknowledge men’s role as gatekeepers of current gender orders and as potential resistors of change. Simply put, if we do not effectively reach males, many of our efforts will either be thwarted or simply ignored.
References


Chapter 8

Prevalence and Chronicity of Psychological Aggression among a Sample of Heterosexual University of Botswana Students

Sophie Moagi-Gulubane
Studies examining the phenomenon of dating violence among college
and university students have proliferated since the early 1980s (Archer &
Makepeace, 1981; Marshall & Rose, 1987; Sugarman & Hotaling, 1989; White
& Koss, 1991). The focus of most of these studies has been on physical abuse
in dating relationships of college students in the United States of America.
Studying physical abuse among young dating couples is indeed important
because it raises vital information about the effects of such abuse.

Very little emphasis has been devoted to studying psychological abuse in
dating relationships, perhaps because the scars inflicted by psychological
aggression are not as readily conspicuous as those of physical abuse. It is
important to understand the dynamics involved in psychological abuse, as
well as any other way abuse presents itself.

Although far fewer than studies on physical aggression, research into
psychological aggression by students is being conducted in the United
States. Very little attention to this phenomenon has been paid in other
nations, particularly in Botswana, in which current anecdotal reports give
the impression that intimate partner femicide is on the rise and a cause
for serious national concern. Although universal, aggression in dating
relationships may manifest itself differently across cultures. By combining
various cultural viewpoints, we may gain a richer and more accurate view
of violence in dating relationships.

The purpose of the study on which this chapter is based was to extend
findings from the United States on psychological aggression to a sample of
undergraduate university students in a non-Western country – Botswana.
The study specifically sought to:

- investigate prevalence rates of psychological aggression among a
  sample of University of Botswana students
- examine chronicity levels of psychological aggression among students
  who experienced psychological aggression; and
- assess gender differences in the perpetration of psychological
  aggression in this sample of University of Botswana dating dyads.

**Literature review**

Psychological aggression in the context of dating relationships is a pervasive social
problem (Holt & Espelage, 2005; Lane & Gwartney-Gibbs, 1985; Riggs & O’Leary,
1996). It may take a number of forms, including suspiciousness that leads to
verbal harassment; saying insulting things; being overly possessive or jealous, and destroying or throwing things (Kasian & Painter, 1992; Lane & Gwartney-Gibbs, 1985). Psychological aggression can be understood in terms of any verbal or non-verbal acts intended to cause psychological pain to a dating partner (Straus et al, 1996). Research has suggested the existence of distinct classes of behaviours that constitute psychological aggression. For example, Murphy & Hoover (2001) identified four types of psychological aggression in college students’ dating relationships: hostile withdrawal; domination or intimidation; denigration; and restrictive engulfment. All of these behaviours invariably cause psychological distress to a loved one.

So pervasive is psychological aggression that research in the United States has indicated that of all types of abuse within intimate relationships of young unmarried couples, psychological aggression takes the lead. Extant literature has revealed that a majority of college students in North America (60–98 percent) report verbal behaviour such as insulting the partner, saying something spiteful to the partner, or threatening the partner (Lane & Gwartney-Gibbs, 1985). In Riggs & O’Leary’s (1996) sample of dating college students, even higher prevalence rates of psychological aggression were reported, with 93.3 percent of the men and 97.5 percent of the women reporting that they engage in some form of verbal aggression against their partner.

These results are similar to those of Clark et al (1994) who, in their study on dating violence among African-American college students, revealed that more than 90 percent of their sample experienced verbal aggression either as a perpetrator or as a victim. Rouse (1988) and Bougere et al (2004) corroborated Clark et al’s (1994) results, finding that over 80 percent of their African-American sample of college students had perpetrated psychological aggression toward a dating partner. These alarming findings indicate that psychological aggression in dating relationships is indeed a significant problem among university students in the United States.

The college-age dating violence literature also shows that the prevalence of acts of psychological aggression is equal or comparable by gender (Bougere et al, 2004; Shook et al, 2000). Findings suggest that college women in dating relationships express psychological aggression either the same or more than men (Clark et al, 1994; Riggs & O’Leary, 1996). This finding points to the need for researchers studying dating violence to pay attention to female-to-male violence as well as male-to-female violence so as to understand underlying processes in dating violence in general, and more specifically in psychological aggression among college students.

North American samples show that psychological aggression is frequently a precursor of and an accompaniment to physical abuse (Follingstad et al, 1990; Kasian & Painter, 1992). If such abuse is indeed prognostic of future physical and more severe victimisation,
attention must be focused on these early markers of abuse in dealing with this issue. At a minimum, greater attention should be paid to the measurement of psychological abuse and its role in predicting or exacerbating emotional distress and dysfunction.

**Methodology**

*Participants:* Participants for this study were a convenience sample of 118 male and 135 female undergraduate students drawn from the University of Botswana. The student body is diverse and representative in terms of socio-economic status, acculturation level, and ethnicity, as this is the sole university in the country. Students were pooled from five faculties within the university: Business, Humanities, Education, Science, and Social Science. Participants were Batswana nationals ranging in age from 18 to 25 years old (mean age was 21 years and 8 months); were unmarried; were involved in a heterosexual dating relationship or had been involved in at least one such relationship in the past. Participation in this study was voluntary.

*Demographic survey:* Demographic information was collected using an author-generated data sheet requesting students’ current age; gender; nationality; ethnicity; marital status; sexual orientation; class standing, and academic major subject. Information on partners’ age and gender was also gathered. Other demographic variables included in the analysis are specific to the dating relationship. They include whether the respondent is currently in a dating relationship or has ever been in one in the past; length of current or most recent dating relationship; and for relationships that ended, when they terminated.

*The Conflict Tactic Scale (CTS2; Straus et al, 1996):* A measure of students’ perpetration of dating violence was obtained through the CTS2, a 39-item scale that measures the extent to which partners in a dating relationship engage in psychological, physical, and sexual attacks on each other. Only the psychological aggression scale was used in this study. The psychological aggression scale includes eight items that measure the extent to which any verbal or non-verbal acts intended to cause psychological pain to a dating partner are used. The items measure either minor or severe psychological aggression. Four items are included in the Minor subscale. An example of the Minor subscale item is ‘I insulted or swore at my partner.’ The remaining four items constitute the Severe subscale with example items such as ‘I threatened to hit or throw something at my partner.’ Participants respond by indicating how many times in the past 12 months they engaged in acts of psychological aggression toward their dating partner. Respondents choose from the following response categories: 0 = *never*, 1 = *once*, 2 = *twice*, 3 = *three to five times*, 4 = *six to 10 times*, 5 = *11 to 20 times*, 6 = *more than 20 times*, and 7 = *not in the past year, but it did happen before*. In the current study, the Cronbach’s alpha for the Psychological Aggression scale was .64.
A descriptive study was conducted to examine the prevalence and chronicity of psychological aggression among University of Botswana students. Frequencies were used to describe the characteristics of respondents and $t$ – Tests for independent samples were used to examine differences between men and women.

**Procedures:** Participants for this investigation were solicited through acquaintance networks at the University of Botswana. The study was co-ordinated through the Department of Educational Foundations, which houses the Counselling Programme. Five Educational Foundations lecturers introduced the researcher to their classes before formal permission for research participation was requested from students. Questionnaires were administered during class time to groups of about 50 students in eight separate classes over a one-week period.

Because the instruments used in this study had not been previously used with the Botswana population, pilot data was collected from 15 University students in Botswana. The demographic characteristics of the participants were as similar as possible to those of students of interest to this study in Botswana. The purpose of the pilot study was to check for comprehension of test items.

Participants were informed of the obligations and potential risks involved, the voluntary nature of the study including the opportunity to withdraw at any time during the course of the administration, and steps taken to maintain participants’ confidentiality. The researcher provided participants with a survey packet that included a cover letter briefly explaining the purpose of the study and ethical obligations to protect participants, participant instructions, and survey instruments. Upon completion of the questionnaires, students were given a sheet outlining resources in the University and the community that could provide help for individuals in violent relationships if needed.

**Limitations:** Because the results were based on a convenience sample of university students, findings can only be generalised to undergraduate dating couples at the University of Botswana. Similar examinations of psychological aggression would be useful to check the generalisability of these data to clinic, same-sex, cohabiting, and non-university dating samples. In addition, the study relied exclusively on self-report data to describe the prevalence and chronicity of psychological aggression. Self-reporting may be limited in its ability to provide a correct picture of violence in dating relationships, given the social undesirability of such behaviours. Straus et al (1996) provided data on the reliability and validity of the CTS2. Their data indicated that under-reporting by women and men in violent relationships was not unusual. For cross-cultural samples, the validity of responses may be further limited by differences in the way that psychological aggression is perceived.
Another limitation of this study is the retrospective nature of the responses. The report of psychological aggression is based on the participants’ recollection of specific psychologically aggressive behaviours. Such memories may be subject to bias as the passage of time may make it difficult to accurately recall events. A final limitation of this study is that data were based on individual reports of personal experience. In other words, the data did not come from couples reporting their own relationship, but rather from individuals in different relationships. Obtaining the perspective of both partners may have made it possible to substantiate mutually violent relationships. Future research should attempt to study ongoing relationships in order to identify dyadic characteristics of dating relationships.

Results
Response rate: Three hundred surveys were collected from undergraduate students in eight classes over a one-week period. Of the 300 surveys collected, 47 were excluded from the analysis for not meeting the inclusion criteria (11 had never been in a dating relationship; 11 were married; 17 were over the age of 25; and 2 were foreign students). Six additional surveys were excluded for missing data. Of the remaining 253 surveys, 15 had been previously collected as pilot data. Because procedures used to collect the pilot data were identical to those used to collect the main data, it was decided to combine the two data sets. Thus, a total of 253 surveys were included for analyses in this study.

Demographic characteristics of the sample: Of the 253 students whose data were included for analysis in this study, 135 (53.4 percent) were women and 118 (46.6 percent) were men. Participants’ ages ranged from 18 to 25 years, with an average age of 21 years and 8 months (SD = 2.16). The sample was fairly representative of all undergraduate years at the university with freshmen (22.1 percent), sophomores (21.7 percent), juniors (16.6 percent), seniors (22.9 percent), and fifth year students (16.6 percent). Participants were representatives from five of the six faculties of the University; Faculty of Business (15.4 percent), Faculty of Education (19.0 percent), Faculty of Humanities (20.2 percent), Faculty of Science (22.1 percent), and Faculty of Social Sciences (23.3 percent). Table 1 presents participants’ demographic characteristics.

Participants’ dating status variables are displayed in Table 2. The majority (86.2 percent) were currently involved in a heterosexual dating relationship while 13.8 percent had been in a heterosexual relationship of at least one month in the past. Participants’ relationship length ranged from 1 to 180 months, with an average relationship length of 25 months (SD = 22.66). Almost all (92.9 percent) were sexually active in their current or past relationships.

Prevalence of psychological aggression: The prevalence rate of psychological aggression is the percentage of the student sample that reported one or more instances of the acts
in the Psychological Aggression scale of the CTS2. Almost one half (49.80 percent) of the students in this sample reported having perpetrated some form of psychological aggression toward a dating partner in the preceding year. Most of the psychologically aggressive behaviours against a dating partner were minor (47.43 percent), such as stomping out during a disagreement, shouting at the partner, and saying something to spite a partner. The prevalence of more severe psychological aggression, such as threatening to hit or throw something at a partner and calling a partner fat or ugly was lower (36.36 percent). The proportion of women who psychologically abused their partners although statistically insignificant, was slightly higher than that of men, with women representing 54.76 percent of all students in the sample who perpetrated psychological aggression toward a dating partner. In addition, women perpetrated 55.83 percent of minor psychological aggression and 52.17 percent of severe psychologically aggressive acts.

Table 1: Demographic Characteristics of Sample Population (N = 253)

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>135</td>
<td>(53.4)</td>
</tr>
<tr>
<td>Male</td>
<td>118</td>
<td>(46.6)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>21.84</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>2.16</td>
<td></td>
</tr>
<tr>
<td>Class standing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freshman</td>
<td>56</td>
<td>(22.1)</td>
</tr>
<tr>
<td>Sophomore</td>
<td>55</td>
<td>(21.7)</td>
</tr>
<tr>
<td>Junior</td>
<td>42</td>
<td>(16.6)</td>
</tr>
<tr>
<td>Senior</td>
<td>58</td>
<td>(22.9)</td>
</tr>
<tr>
<td>Fifth Year</td>
<td>42</td>
<td>(16.6)</td>
</tr>
<tr>
<td>Faculties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business</td>
<td>39</td>
<td>(15.4)</td>
</tr>
<tr>
<td>Education</td>
<td>48</td>
<td>(19.0)</td>
</tr>
<tr>
<td>Humanities</td>
<td>51</td>
<td>(20.2)</td>
</tr>
<tr>
<td>Science</td>
<td>56</td>
<td>(22.1)</td>
</tr>
<tr>
<td>Social Science</td>
<td>59</td>
<td>(23.3)</td>
</tr>
</tbody>
</table>
Table 2: Characteristics of Participants’ Relationships (N = 253)

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>#</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dating status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently dating</td>
<td>218</td>
<td>(86.2)</td>
</tr>
<tr>
<td>Dated in the past</td>
<td>35</td>
<td>(13.8)</td>
</tr>
<tr>
<td>Relationship length, months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>25.17</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>22.66</td>
<td></td>
</tr>
<tr>
<td>Current and past relationship sexual activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually active</td>
<td>235</td>
<td>(92.9)</td>
</tr>
</tbody>
</table>

Chronicity of psychological aggression: A second set of statistics, chronicity, was used to indicate the average number of times psychologically aggressive behaviours reported by dating dyads in this sample occurred in the previous 12 months. The results of this study indicate that the average number of times the acts of psychological aggression occurred among students who reported perpetration of psychological aggression was 17.52 (SD = 22.31) times in the past year, with men perpetrating more acts (M = 21.05, SD = 29.01) of psychological aggression than women (M = 14.59, SD = 12.82). There were more acts of minor psychological aggression (M = 12.56, SD = 15.93) than severe psychological aggression (M = 7.61, SD = 10.64). Men perpetrated more acts of minor and severe psychological aggression – (M = 15.15, SD = 20.95) and (M = 9.02, SD = 13.08) – respectively. Women’s chronicity level for minor and severe psychological violence was (M = 10.51, SD = 10.10) and (M = 6.31, SD = 7.69). None of the differences in the chronicity of the different forms of psychological aggression between women and men were found to be statistically significant. The descriptive statistics for the CTS2 Psychological Aggression scale are displayed in Table 3.

Discussion of findings

Findings from this study make it clear that psychological aggression is a pervasive problem in this sample of Batswana university students, with almost one-half (49.80 percent) of the 253 students reporting having perpetrated some form of psychologically aggressive acts toward a dating partner in the preceding year. This is consistent with a large number of studies with North American college students (for example, Bougere et al, 2004; Shook et al, 2000). Although the prevalence rates for psychological aggression reported by this sample of Batswana university students can be considered high at 50 percent, these rates were lower than those of
psychological aggression reported in previous college student studies in the US. For example, Shook et al (2000) reported prevalence rates of 83 percent for women and 80 percent for men. Similarly, Bougere et al (2004) found that 82.35 percent of men and 83.52 percent of women in their sample admitted that they perpetrated some form of psychological aggression toward a partner. It could be that psychological aggression is less prevalent among Batswana college students, or that behaviours consistent with psychological aggression were under-reported by Batswana students in this sample.

As in previous studies, most of the psychologically aggressive behaviours against a dating partner were minor (47.43 percent), such as stomping out during a disagreement, shouting at the partner, and saying something to spite a partner. The prevalence of more severe psychological aggression, such as threatening to hit or throw something at a partner and calling a partner names was lower (36.36 percent). The proportion of women who psychologically abused their partners was slightly higher than that of men, with women representing 54.76 percent of all students who perpetrated psychological aggression toward a dating partner. In addition, women perpetrated 55.83 percent of minor psychological aggression and 52.17 percent of severe psychological aggression. This result corroborates earlier findings (for example, Riggs & O’Leary, 1996), which reported women’s prevalence of psychological aggression in dating relationships to be somewhat higher than that of men.

The higher prevalence rates of psychological aggression by Batswana college women should be cause for concern, given that North American research has established that psychological aggression is frequently a precursor and an accompaniment to physical assault in college students’ dating relationships (Follingstad et al, 1990). If psychological aggression is indeed prognostic of physical assault, the high prevalence rate of psychological aggression by University of Botswana female students may be indicative of hidden physical assaults in their dating relationships. At the very least, these female students may be at serious risk of future physical violence in their dating relationships. Attention must be focused on this early marker of violence in dealing with the issue of dating violence among Batswana students. This is particularly critical as Botswana is currently experiencing a serious problem of intimate partner femicide among young dating couples. Efforts should be focused on prevention and intervention strategies for psychological aggression before the issue escalates to physical harm and senseless murders. There is a prime opportunity for counselling psychologists to educate about relationships, with the goal of promoting non-violent dating relationships and non-violent long-term relationships.
Table 3: Descriptive Statistics for the CTS2 Psychological Aggression Scale and Subscales by Gender of Participant (N = 253)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Gender of Participant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Psychological Aggression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>69</td>
<td>57</td>
</tr>
<tr>
<td>Prevalence (%)</td>
<td>27.27</td>
<td>22.53</td>
</tr>
<tr>
<td>Chronicity (M)</td>
<td>14.59</td>
<td>21.05</td>
</tr>
<tr>
<td>Range¹</td>
<td>1 – 56</td>
<td>1 – 160</td>
</tr>
<tr>
<td>(SD)</td>
<td>12.82</td>
<td>29.81</td>
</tr>
<tr>
<td>Minor Psychological Aggression Subscale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>67</td>
<td>53</td>
</tr>
<tr>
<td>Prevalence (%)</td>
<td>26.48</td>
<td>20.95</td>
</tr>
<tr>
<td>Chronicity (M)</td>
<td>10.51</td>
<td>15.15</td>
</tr>
<tr>
<td>Range</td>
<td>1 – 46</td>
<td>1 – 100</td>
</tr>
<tr>
<td>(SD)</td>
<td>10.10</td>
<td>20.96</td>
</tr>
<tr>
<td>Severe Psychological Aggression Subscale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>48</td>
<td>44</td>
</tr>
<tr>
<td>Prevalence (%)</td>
<td>18.97</td>
<td>17.39</td>
</tr>
<tr>
<td>Chronicity (M)</td>
<td>6.31</td>
<td>9.02</td>
</tr>
<tr>
<td>Range</td>
<td>1 – 33</td>
<td>1 – 60</td>
</tr>
<tr>
<td>(SD)</td>
<td>7.69</td>
<td>13.08</td>
</tr>
</tbody>
</table>

Note: Higher scores indicate greater perpetration of psychological aggression.

Clinical implications of the study
Findings from this study clearly portray the significance of psychological aggression among Batswana university students both in terms of the numbers of students currently engaged in psychological aggression, as well as possible future implications for violence in later heterosexual intimate relationships. As suggested by Roscoe & Benaske (1985) college students are at a formative period in their lives, especially in relation to the development of appropriate patterns of behaviour with an intimate partner. The patterns manifested at this age are often enduring features of their future relationships. There must be concerted prevention and intervention efforts aimed at combating the problem of violence of any type among university students in Botswana.
Conclusion and recommendations

Within the University of Botswana, the relatively new Counselling Centre should increase its visibility among the university community, especially students, by taking a leading role in developing programmes geared towards dating violence prevention. It would be especially beneficial for the Counselling Centre to train students concerned about issues of dating violence on campus and include them as part of the outreach effort. The potentially helpful role of peers has been noted by Lloyd (1991). Peers may be even more effective than adults in reaching other students because they may be perceived as better understanding the issues or having greater credibility. This is especially important for a newly established Centre in a community where cultural constraints may prevent students from talking to adults – let alone strangers – about problems in their dating relationships.

Secondary intervention strategies should be targeted toward groups at high risk of experiencing violence in their dating relationships, for example, those who have previously been in a dating relationship or who have grown up in homes where they observed violence between family members (Lloyd, 1991). Lloyd also suggested tertiary intervention activities targeting individuals who are currently experiencing violence in their dating relationships. Tertiary interventions should include:

- a thorough dating violence assessment by a professional psychologist; and
- on the basis of the assessment and the practitioner's clinical judgment, making a decision as to whether to engage the couple in conjoint therapy or to refer the individual partners to gender specific treatment.

For women, referral to support groups and advocacy services may be important, as women in violent relationships are not able to deal with the trauma of the violence until they have obtained adequate support and resources. When such issues have been addressed, a woman in a violent relationship may wish to address other issues in more traditional therapy (Dutton, 1996).

This study was an initial step in determining the prevalence and chronicity of psychological aggression in a sample of heterosexual University of Botswana students in dating relationships. The preliminary findings of this modest study indicate that psychological violence may be a serious problem among Batswana university students. In addition, the results suggest that women and men in dating relationships perpetrate psychological aggression at comparable rates. This highlights the importance of addressing mutually violent relationships in prevention and treatment programmes. This study can provide useful and important information, especially if considered exploratory in nature and followed by studies using larger, more representative samples.
References


Chapter 9

The Voices of Sex Workers:

Implications for adult education strategies

Peggy Gabo Ntseane
This chapter argues that sex work in Southern Africa operates in a context defined by male violence and HIV and AIDS. This chapter presents the findings of a study that assessed the situation and needs of sex workers in the context of HIV and AIDS. Three main research areas were focused on by the needs assessment study:

1. describing the situation and extent of sex work in communities or villages
2. identifying the problems and needs of the sex workers operating from that locality; and
3. identifying the perceived strategic response to the situation of commercial sex work.

The theoretical framework discussed in the chapter shows that the social construction of masculinity, as well as the prevalent poverty in some countries of the region, has pushed some men and women to work as sex workers. The qualitative research methodology that was used to collect and analyse data on the needs of sex workers is also presented. This is followed by findings of the study and their implications for an alternative HIV and AIDS education and prevention strategy that privileges male involvement in HIV and AIDS infection education.

**Literature review**

The literature on sex work (William, 1999; Campbell, 1997; Kempadoo & Doezema, 1998) shows that commercial sex is a thriving industry in developing countries in spite of a hostile environment characterised by stigma, exploitation and violence against sex workers, regardless of their gender. This is true in Southern Africa, of which Botswana is a part. Limited research and debates on sex work in this region identify three main causes: poverty; the social construction of masculinity, and slavery in the region. According to Goral (2003), difficult living conditions in Zimbabwe have resulted in extreme poverty which has pushed some women and men into sex work. In South Africa, studies have shown that female sex workers come from the impoverished rural areas in South Africa and neighbouring countries to engage in sex work with mine workers (Campbell, 1997).

The second cause of sex work, namely the social construction of masculinity, has been described in the literature (Ulin, 1992; Ood & Jewkes, 1997; MacDonald, 1996) as the powerlessness of women (wives, girlfriends, or sex partners and sex workers) to negotiate safe sex in the face of male reluctance to use condoms. Furthermore, cultural beliefs, myths and misconceptions are used in patriarchal societies like Botswana to
ensure that women and girl children provide sex for male recreation. Examples of this include the belief that having sex with a young girl cleanses a man’s reproductive system including the HIV and AIDS virus. Another belief in Africa and even in Botswana is that it is macho to have multiple sex partners.

In other debates it has been argued that sex trade is a form of slavery, as evidenced by child trafficking usually from developing countries to developed countries. The International Labor Organization study revealed that the sex trade represented 2–14 percent of the gross domestic product of Asian countries (Kempadoo & Doezema, 1998). Debates in the region have also suggested a link between sex work and tourism, providing arguments for recognising sex work/prostitution as an economic factor.

Existing literature has also related sex work to HIV and AIDS. For example, a study by William (1999) in South Africa found that 69 percent of sex workers were HIV positive, while that of their clients (miners) was only 25 percent. William concluded that this shows that sex worker education programmes and free condoms in South Africa have not stopped commercial workers from having unprotected sex. Indeed, the current focus on condom use advocated by UNAIDS for sex workers has been challenged from a gender perspective on the basis that forcing sex workers to be tested for HIV and AIDS and promoting condom use can be disempowering. From this perspective, it is argued that the focus should be on sex workers’ rights.

**The Botswana context**

Botswana has one of the highest rates of HIV prevalence in the world, with a 17.1 percent national infection rate (MoH, 2007). This is double the rate observed ten years ago. HIV and AIDS situation analysis studies (Seloilwe & Ntseane, 2000; Ntseane, 2003) support the notion that the main reason for engaging in commercial sex work for women is poverty and unemployment. As one respondent put it:

> We don’t like what we do but what else is there, not educated, having given up finding a job, what would you do? We have no choice but to get money for what you would otherwise give for free and still risk HIV infection (Ntseane, 2003:24).

The current poverty and unemployment data show that 36.7 percent of the households in Botswana live below the poverty datum line (Botswana Government Plan 9:24), while the unemployment rate is 18 percent (CSO, 2006). It is important to mention that due to increasing poverty and unemployment rates in the region, sex workers also cross borders (legally or illegally) to do business in neighbouring countries. For example, Botswana sex workers cross borders in the region illegally
with truck drivers, while most Zimbabwean sex workers operating in Botswana are illegal immigrants who cross the Botswana-Zimbabwe border at un gazetted areas.

Poverty in the rural areas of Botswana is pushing young people to move to urban areas where they hope to get employment. However, when they do not get the expected employment or get low paying jobs, they engage in other income-generating activities. Sex work is one of the alternatives available, even though it is illegal. Based on this background, this chapter presents results of a study that was conducted as an effort to identify the needs of sex workers as potential beneficiaries of future HIV prevention and empowerment activities.

**Methodology**

**Participants and procedures:** The study was conducted in Tlokweng – a village in close proximity to both Gaborone City and the border between Botswana and South Africa. Based on the data from this study, sex work can be defined as the exchange of sex for material benefit without emotional commitment. Although it is mostly associated with money, participants in this study mentioned that sex could also be exchanged for goods and services. Descriptive qualitative survey data collection methods were used for this study. This approach was relevant because it allowed key informants, such as relevant government departments, non-government organisations, local leadership, and the community to articulate their views and opinions regarding sex work in their community. The approach also enabled the different categories of sex workers and their clients to share their experiences, challenges, frustrations and ideas to improve their working conditions.

Sampling was purposeful in order to address issues of location, sex work categories, community population diversity, gender and experiences. A total of 150 people participated in 10 focus groups. Focus group participants included men; women; youth (both in school and out of school); sex workers (locals and those from neighbouring countries); sex work clients (locals and truck drivers from the region); employees from relevant government bodies and NGOs, namely social work, health, schools; members of the business community (hotels and bars); and the police service. The number per focus group ranged from 5–10. In addition 15 individual interviews were conducted with representatives from relevant key stakeholders. These included human rights agencies; community leaders (councillors, chiefs and headmen); donor agencies; HIV and AIDS prevention organisations, and immigration departments. On-site observations were undertaken at sex work sites such as the truck driver stops; border posts; bars and traditional beer outlets; sex workers’ leased accommodation; road roundabouts (circles), and motels. This chapter focuses only on the views of sex workers.

Data analysis occurred concurrently with data collection to facilitate further probing and clarification of issues and saturation of themes. By using the constant comparative
qualitative data analysis approach (Bogdan & Biklen, 1992), comprehensive coding, categorising and classification of the themes emerging from the data was ensured.

**Research findings and data analysis**

Data from a triangulation of data sources, namely, individual interviews, focus groups, and observations revealed the following five major findings:

- Perceptions of sex work differed for female sex workers and male clients of sex work.
- Sex workers were not a homogeneous group but had several categories.
- In a context characterised by HIV and AIDS, the risks associated with sex work outweigh the benefits of the business.
- Female sex workers feel threatened by the emerging male involvement in sex work.
- HIV prevention strategies should also address the issue of economic empowerment.

**Different perceptions of sex work**

A majority of the sex workers (female) perceived their involvement in sex work as an income-generating activity. Their clients (mainly male) see their involvement as recreational, and a source of pleasure. This is how one male client explained it:

> *Some women in our society need money for real. So if you have a P20.00 to spare helping the sex worker to feed her children is an ethical thing to do. Isn’t it?*

Although at the time of the study, data showed that the majority of sex workers operating in the study area were Zimbabwean girls, it is important to mention that data from interviews revealed that this was a new trend. One respondent said:

> *Zimbabwean girls started coming in big numbers since January 2003.*

A profile of the sex workers who participated in this study shows that their ages ranged between 12–50 years and most were single women leading a hand-to-mouth existence and surviving on the proceeds of each day’s encounter. Most of the sex workers are unemployed, out-of-school young women, with low literacy skills. On average, each sex worker reported having between 2–5 sexual contacts per day, and an average of 20 sexual contacts per week. Asked about condom use, these sex workers stated that condoms are used in less than 10 percent of these sex encounters because most clients do not like condoms.
Information on transaction prices show that citizen sex workers ask for higher prices due to a relatively higher standard of living compared to sex workers from other countries. For instance, local sex workers charge P20.00–P50.00 with a condom, and P100–P200 without a condom. The Zimbabweans’ prices range from P2.00–P5.00 with a condom and P20.00–P50.00 without a condom. Asked why the latter asked for so little, one Zimbabwean sex worker said:

*It is desperation my sister. When you think of the situation of hunger at home, what can you do? You just tell yourself that half a loaf is better than no bread.*

Although most respondents did not say anything about male sex work, a few female sex workers alluded to the growing competition from male sex workers. This is what one female sex worker had to say:

*These days some clients tell us that they prefer male sex workers.*

Both the community and the sex workers observed that retired commercial sex workers introduce their own girl children to the sex work business. In situations where sex work is the only source of income for the family, it makes sense to introduce the child if she is of the age that is preferred by customers. Observation data revealed that another characteristic of sex work is that both the workers and their clients drink excessively. Asked why they drink prior to going to work, most said that it was a key business strategy.

*When you are drunk you don’t have to worry about the cultural expectations of respect and good manners or being a real Motswana or citizen of Botswana by birth woman.*

Sex work in Southern Africa is thriving because of poverty and high rates of unemployment in the region. Increasing illegal migration, unemployment and poverty in the whole region facilitate sex work activities in spite of its illegal status. Since clients of sex workers are mostly married men who do not like to use condoms, HIV and AIDS prevention will continue to be a big challenge in this region.

**Categories of sex workers and clients**

Sex workers in Botswana are not a homogeneous group. Categories of sex workers identified by this study include school-going youth; unemployed out-of-school youth; educated working class; women addicted to alcohol, and retired part-time sex workers.
School-going youth sex workers (12–15 year olds)
Except for those with regular customers, sex work is only conducted on weekends in this category. The major reason advanced for sex work by this category was the need for money to buy and maintain cellphones: most of the sex workers are therefore not in the business for poverty and unemployment reasons. One of the junior community schoolgirls explained:

There are pimps who recruit us for the businessmen in the community and they always ask if we have cellphones or if we know any girls who would like to have cellphone.

It was reported that a small percentage (20 percent) of the youth engages in sex work because of poverty, and the need to take care of their dependents. For most of them, the transaction price depends on the need, such as having to buy food or clothing at the time, but usually it is payment in kind. Examples given were second-hand cellphones, food, an outing such as going to a party, being driven in a BMW car, money for a hair-do or a g-string panty.

Unemployed out-of-school youth sex workers (16–25 year olds)
These are the majority and described themselves as full-time sex workers. As one put it:

It is a job, how do you survive without money? Tlokweng village is our Gauteng or gold mine in Johannesburg1 because of the truck drivers and its proximity to Gab City.

Although all types of men are clients, most of these clients are married men from Gaborone City. Members of this category of sex workers are likely to occasionally engage in mobile sex work, such as going to South Africa with a client who is a truck driver.

Educated working class sex workers (30–45 year olds)
These workers use popular Tlokweng sex work sites such as the shopping complex, the truck drivers’ stop and motels as a pick up and drop off point. Both the sex workers and their clients seem to rely on the use of cellphones instead of waiting in the bar or hanging out along the streets. Clients are married, educated, and are high-powered officers or rich business people working in Gaborone, including non-nationals on business trips. One respondent described this group as follows:

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1 From time immemorial, Johannesburg has been the hub of employment for Batswana labour migrants.
This is the group that makes real money in the business. They charge P500.00 or more. They drive nice cars and have built nice houses.

This category of sex worker is also likely to accompany their clients to other countries. They are likely to use condoms almost all the time. Sex work is important for this category because most of them hold low paying jobs, such as being a secretary, clerk or shop assistant. Said one respondent:

How do you survive with P600.00 or even P1000.00? You need someone to pay for transport, another for cooking gas, another for groceries or goat meat once in a while, one for rent, in addition to the so-called permanent boyfriend.

Alcohol addicted sex workers (25–45 year olds)
These sex workers are identified as women who spend the whole day drinking at bars and traditional beer outlets, hence the label alcohol addicts. When they are drunk they offer sex in exchange for money or more beer. These workers have sex anywhere after sunset, for example, behind a hut at a traditional drinking place. Payment is usually the drink already consumed. This is how one of them put it:

When you ask for money the client gives you P2.00 and remind you that they have been buying you beer since 10 in the morning.

 Asked why they spent the whole day drinking instead of working or looking for a job, all responses alluded to the frustration of being unemployed, in spite of the wish to get themselves and their families out of poverty.

Retired but part-time sex workers (45–50 year olds)
These are older women who are supposed to be retired from the sex work business but are occasionally forced to try their luck to feed the family. They are likely to be found at traditional beer outlets especially at month-ends. They ask male beer customers to buy them alcohol, but are very careful not to be drunk because the strategy is to monitor the man’s alcohol level. When the potential sex client opens his wallet to buy drinks, the sex worker strategically peeps to check if he is worth her time. If the wallet is ‘promising’, that is the catch for the day. One woman described her business day at a very busy traditional beer outlet:
You see this one is mine today. I have to find a way of stealing at least P20.00. I have to do this because after sex he will only give me P5.00 and it will be too late honey to complain.

Individual interviews revealed that a sex worker knows it is time to retire when even older truck drivers do not want her. They then introduce their daughters or needy relatives to the business. This category of sex workers always operates small business jobs on the side. Examples given were a kiosk, a traditional beer outlet or a cleaning job.

The finding that sex workers are not a homogeneous group is important for it indicates that sex work is often much more widespread than data suggest. This has implications for the definition of sex work, who the sex worker or client is, and why different people go into the sex work business. For instance, in poverty situations such as in Southern Africa, a sex worker is no longer the traditional conservative illiterate young girl who hangs around bars; she could actually be an educated, unemployed or working woman who needs to supplement her meagre salary. This study also found that sex between men is increasing, as clients prefer the latter. Understanding the different experiences, circumstances and needs of different male and female sex workers and their clients is crucial for HIV and AIDS prevention strategies to be effective.

**Sex work as a high-risk business**

All participants agreed that the risks of the sex work business in the HIV and AIDS era outweigh the benefits, regardless of the sex worker’s situation. Risks include violence, HIV infection, stigma, discrimination and exploitation. Sex workers fight amongst themselves for potential clients. The results of this study showed that some injuries were self-inflicted, as attested by female sex workers’ fights over potential male clients. Some clients acknowledged that sex workers steal from them. And some clients assault sex workers. Sex workers are also subjected to violence from the male population not only in the business, but also from some community members. Several sex workers echoed the following statements:

> When we report to the police after being robbed by boys in this community, some police officers laugh and ask what we were doing on the streets at night.

> One day I was gang raped but I did not report because these boys told me that as sex worker the police will not take me seriously.
Sometimes it can be rough in this business, like when you meet a violent and bad client who has no respect for women. They can beat you the whole night and worse not pay you after that.

Most of this violence goes unreported because of the low status of the work of sex workers, discrimination and their lack of recognition by society. If violence in other spheres is not condoned, surely it should be the same even for those workers who choose this business.

Another major risk is HIV infection. Every respondent knew of at least three deceased sex workers because of AIDS and others who are currently sick. One of the sex workers shared this:

When I started the truck mobile sex business we were 18 who met here in Tlokweng from different parts of Botswana. Eleven are already dead from HIV and AIDS, three are terminally ill and I am positive. But I cannot stop the sex work business because I have two kids to feed.

Although aware of the dangers of HIV and AIDS and having abundant access to free condoms, sex workers followed the common principle, that the customer is always right.

You always start with the negotiation to use a condom but if the man refuses a condom as a sex worker you must immediately drop the subject of condoms and go for the money. If you don’t, he takes his business elsewhere. So unless all sex workers can agree on enforcing condoms in the business, no one will use a condom consistently.

Although sex work in the HIV and AIDS era does increase risks for the sex workers, the risk of being infected with the HIV virus is not a priority. It was clear that sex work is a means by which poor women survive.

With this miserable life of poverty, who worries about death anymore? I would rather risk being infected with the HIV and AIDS virus by engaging in unprotected sex with a rich man whose wife died of AIDS. You know why? Because I will live a short but happy life, build my children a decent house and feed them well for the next three or five years. So I will leave them in a better orphanhood status. Don’t you think?

This supports Weinstein’s (1999) belief that risk is a motive to change, but it is not always powerful enough to promote it.
Male involvement in sex work

Although the focus of the study was on female sex workers and their clients, one finding of this qualitative study was that female sex workers reported the emerging competition from male sex workers. Although not many, a small proportion of the clients (men) were in fact interested in male sex workers. This is how one frustrated female sex worker put it:

*I have male clients who now want male sex workers, they often ask questions like where does one find them in this area?*

Several female sex workers who claimed to have travelled in the region with truck driver clients reported having been forced to provide sex in strange ways ‘as if they were having sex with other men’. In agreement in a focus group with junior secondary schoolboys, some boys confirmed that local businessmen occasionally asked them to find girls or boys who want money in exchange for sex. This finding confirms the literature on the topic of men who have sex with other men. For example, Phaladze & Tlou (2001) observed that even with the evidence that sex between men was a common reality in prison, the legal and social discrimination against gay people, and denial of their existence, militate against HIV prevention strategies. In another study, Patai et al (1998) found that even with the predominate denial that men have sex with other men, some of the study participants admitted that anal sex does happen in Botswana society, hence the label *matanyola*. Denying male involvement in sex work puts many women (sex workers or not) with whom men have sex at risk of HIV infection.

In a culture where sexual decision-making is the prerogative of men, coupled with the social norms that tolerate their likelihood to have multiple sexual partners, as well as intergenerational sex, male involvement in promoting safer sex cannot continue to be overlooked. Since society expects men who sleep with other men to be heterosexual, this means they live a double life. As this study affirmed, the majority of female sex workers’ clients are married men who could actually be hopping between heterosexual and homosexual sexual partners. Ignoring this has adverse effects on HIV infection and transmission.

As Phaladze & Tlou (2001) rightfully concluded, the exclusion of males has serious disadvantages for women in a context where women cannot initiate HIV and AIDS prevention strategies without their spouse’s or sexual partner’s approval. For example, several studies with sex workers and their clients, including this one, have shown that when sex is used as an exchange, most men do not want to use a condom. Thus, it is argued that knowledge gained by women can only be useful if they are empowered enough to prevent and avoid risky sexual behaviours. One would argue that this is still
not enough: men need to be aware that as decision-makers in society, they need to address the problem of male violence against women, especially sex workers.

**HIV/AIDS prevention for sex workers should include economic empowerment**

Another major finding of the study revealed that all participants want HIV and AIDS intervention strategies to provide alternative income-generating activities for the younger sex workers, especially those youth still in school. One of the in-school young people stressed:

*There is a lot of peer pressure to be connected i.e. own a cellphone. If some parents cannot afford to buy these material things for us, then sex work is still the only option.*

For the out-of-school youth sex workers, the need is production skills or training in skills development programmes that have in-built job opportunities. An ex-sex worker, now a community youth project member, emphasised this point:

*This project has given us business skills such as gardening, candle making, etc, but we are not using them because of lack of capital to start our dream business ideas. If those who trained us were expecting us to get salaried jobs, they should have asked us. Educated people from this village and Botswana as a whole are unemployed. So how can I expect to get a job in Gaborone with Grade 3 and a skill without papers?*

The main purpose of this youth project was to encourage sex workers to leave sex work by teaching them about HIV and AIDS and alternative income-generating skills. As can be seen from the above quote, the prescribed alternative income-generation activity to sex work is obviously not perceived as more lucrative than sex work. No wonder most sex workers, with the exception of the in-school younger youth (12–15 year olds) said it was time to legalise sex work:

*We need a professionally run centre just like those in South Africa. This will ensure that we get paid for the service that we provide at this high risk. There should be doctors to provide us with proper health services.*

Some workers, youth and business people also mentioned that a business centre should be considered because as one put it:
Nothing will get these women out of this business. And with HIV and AIDS, these poor women have to be protected somehow in this activity.

In agreement, another community leader said:

We know that some of these women who sell their bodies are assaulted and cheated by their clients, but because sex work is not legal they don’t report such cases and even if they do, they lie, hence they are likely to lose such cases. I think they need to be protected somehow.

People need money to survive; the poor are vulnerable to HIV and AIDS because without alternative employment opportunities (and low levels of education), casual and full-time sex work is the only viable source of livelihood for some people. The statement below is representative of the voices of Botswana sex workers:

Having given up on getting a job, not educated, and coming from a poor family, the violence and risk of HIV and AIDS in this business is nothing.

Homosexuality and sex work in Botswana needs to be addressed openly in Botswana. The violence from male clients described by female sex workers in this study is critical if we are to devise HIV education, counselling and prevention strategies that will ensure effective male involvement in the fight against HIV and AIDS. Any positive effort has to include male involvement in sex work, and this will require evidence-based strategies.

**Discussion of findings**

Aware that Botswana is one of the worst affected countries by HIV and AIDS, the government has declared HIV and AIDS an emergency and has put in place policies, infrastructure and programmes to control the epidemic and mitigate its diverse effects. Since the HIV virus in Africa is mainly transmitted through heterosexual sex and mother-to-child transmission, the government’s main HIV and AIDS education prevention strategy has to date emphasised behavioural change. The strategy is affectionately called the ABC strategy. The ‘A’ is for Abstain from sex till marriage; the ‘B’ is for if you cannot abstain till marriage, have sex but Be faithful to one partner. If both A and B are too difficult to practice, have multiple partners but use a Condom every time you have sex (‘C’).

It is clear that the current Botswana HIV and AIDS prevention strategy of ‘Abstain, Be faithful to one partner, and Condomise’ is irrelevant to the plight of sex workers. Clients
of sex workers (mostly married men) and male foreigners in transit (such as truck drivers in the region) do not want to use condoms, and are prepared to pay a premium for unprotected sex. Therefore, there needs to be an alternative strategy. Instead of a focus on HIV and AIDS, it is suggested that an alternative strategy should address poverty and unemployment, and other relevant social problems of commercial sex workers.

The alternative strategy should be context and target specific, and the focus should be on addressing poverty and unemployment, and have the ability to influence policies to be more pro-poor and gender sensitive. The poverty of sex workers is a dual one: it is monetary and also has a human rights dimension. The first takes the form of insufficiency of financial resources, while the second relates to inadequate education (especially for young girls), and the exclusion of sex workers from access to basic services. Access to business centres and professional training is also a challenge.

The illegal status of sex work in Botswana is evidence of a lack of appropriate legislature. Related to this is the demand by the Botswana sex workers for a legally run professional sex work centre in Tlokweng. This finding confirms results of a study by Peterson (1989) on ‘sex workers voices’ that revealed that prostitutes from around the world demanded full recognition of women’s rights. Fighting poverty and lack of male involvement should be a main objective of HIV and AIDS prevention among this vulnerable group.

Funding of income-generating activities should consider targeting unemployed men and women. Even more importantly, mainstreaming HIV and AIDS in financing institutions such as the Citizen Entrepreneurial Development Agency (CEDA) and District Multi-Sectoral AIDS Committees (DMSAC) by committing both financial and skilled human resources would ensure that sexual minorities such as sex workers, homosexuals, gays and lesbians have access. Special attention should also be given to production skills with output. Project participants have observed that acquiring business skills without the capital to start individual or group businesses will not take women completely out of the sex business.

Finally, the government of Botswana should legalise voluntary commercial sex work and establish a working group that will look into the establishment of a supportive legal framework for sexual minorities who are engaged in voluntary commercial sex work. In particular, reform of sections 155 and 158 of the Penal Code that prohibits prostitution is necessary. Future legislation needs to take into account that people engaged in voluntary commercial sex need to be able to access government services such as health facilities, HIV and AIDS prevention and care services, as well as police protection. At the same time, human trafficking and ‘pimping’ or living on the gains of others engaged in commercial sex work should be outlawed. Access to services, and the ability to legally form associations, will enable sex workers to create safe and
hygienic working environments. The HIV and AIDS epidemic will not be vanquished until African countries come to terms with the hidden (but widespread) realities of the relationship between HIV and AIDS and other factors such as commercial sex, homosexuality and violence. Stigma and denial of the contributions of such socio-economic factors can only fuel the epidemic.

**Implications for adult education practice in an HIV/AIDS context**

Overall, the findings of this study have confirmed that education and communication remain critical components of what can be done to achieve behavioural change that will lead to the reduction of HIV and AIDS transmission. In particular, there are no prevention programmes that focus on men. This is attested by the ignorance displayed by male clients of female sex workers about HIV and AIDS and other health issues. For example, male truck drivers from other countries in the region who were interviewed in this study believed that traditional herbs found in their countries prevented them from HIV infection. The result of this ignorance is unsafe sex with Botswana sex workers. Patai et al (1998) found that a significant number of men in Botswana are still not aware that sexually transmitted diseases enhance HIV and AIDS transmission, and prefer to consult traditional doctors or get treatment over the counter.

Asked to suggest the focus of future HIV and AIDS education and training prevention intervention strategies, participants acknowledged that a lot was already being done on the HIV and AIDS epidemic, but there was still room for empowerment activities. They particularly stressed the need for a focus on information and training on the risks of sex work in the context of HIV and AIDS, as well as skills training for poverty and unemployment reduction activities. Community representatives emphasised a focus on training that deals with educating all people on moral and ethical issues. They see information sharing and consultation with all actors in the sex business as the most appropriate strategy. Based on these suggestions, the role of adult education in HIV and AIDS prevention cannot be overlooked.

**Adult education strategies**

Informed by the cultural theory of learning (Tomasello, 1999; Wenger, 1999; Plumb et al, 2003), I advocate for HIV and AIDS adult education that uses participatory approaches with small groups of people or what Wenger (1999) calls ‘communities of practice.’ Cultural theorists of learning advocates argue that informal adult learning has focused on the individual and has ignored the ‘collective nature of people’s experiences’. They argue for an inclusion of everyday learning processes (Plumb et al, 2003). Almost every family in Botswana is affected or infected by HIV and AIDS;
the HIV and AIDS experience is a collective one, and everyday informal learning that takes place should not be ignored. Over the years Botswana men, like other groups of people in the population, have learnt from the experiences of the HIV epidemic. It is therefore timely that the involvement of men in future HIV education and information prevention activities be more focused if they are to make a difference.

Although men’s involvement has been minimal or not visible in the past, an approach that focuses on men is likely to be effective. This is because support networks, such as those of sex workers and homosexuals, can be used not only to negotiate meaning, but also to produce capacity that could make possible practical actions around physical and cultural challenges. Sex workers can join together in small groups of practice to understand shared experiences and negotiate meaning for effective HIV and AIDS prevention in their context. The suggestion of reaching people through entertainment confirms Dyk (1999), who argues that entertainment has to be used increasingly to address sexual responsibility and HIV and AIDS. In his words, ‘sing and the world sings with you, lecture and you lecture alone.’

According to Harrison et al (2000), a successful peer education programme transfers control of knowledge from the hands of experts to lay members of the community, making the educational process more accessible and less intimidating. The Tlokweng youth made the suggestion that youth programmes be run by the youth, because peer education will allow group debate and negotiation of messages. Powerful examples exist throughout the world about the success of peer involvement in prevention strategies. Peer counselling has, for example, been very successfully applied in South Africa.

In spite of the dangers and risks of sex work, full-time sex workers and ex-sex workers still see sex work as the most reliable source of livelihood in Botswana due to increasing poverty and unemployment rates. There is an interconnected relationship between gender inequality and sex work. Education and communication remain critical components of the reduction of HIV and AIDS transmission. An HIV and AIDS prevention strategy is needed that is target specific (ie that targets female sex workers and male sex workers), and that emphasises participatory HIV and AIDS prevention activities. With appropriate legislation in place, sex workers (male or female) can organise and talk openly about their issues in the context of HIV and AIDS, and adult education can facilitate this.

References


Chapter 10

Gender Research:

The importance of data collection and analysis of male involvement in reproductive health issues

Elizabeth Poloka Mukamaambo and Venant Rafael Nyonyi Mutabihirwa
Gender refers to characteristics of women and men that are socially constructed, while sex refers to those characteristics that are biologically determined. Although people are born female or male, they learn to be girls and boys who grow into women and men. Ideally, no one should be offered lesser opportunities just because they were born male or female. However, it has been established through different sources of data collected that this is not the case.

Data shows that the opportunities provided to females are usually meagre compared to those of males. Furthermore, it has been established that the differences in these opportunities are based on societal expectations of what women ‘should’ do, and what they ‘should’ possess in terms of assets. For example, in Botswana until very recently, rearing cattle was expected to be done by males, while women were expected to keep chickens. Women dominated issues related to reproduction. Male involvement in reproduction was based solely on their role during conception. To this effect, all programmes and policies related to reproduction were developed for women and implemented on women.

Even taking children to under-five clinics was the domain of women alone. If a man were seen among women at such clinics, other women would gossip about the whereabouts of the child’s mother. This system excluded men from reproductive health issues, which has resulted in men being ignorant about these issues.

The HIV pandemic has made it impossible for this status quo to remain unchecked. There is a need for gender research and mainstreaming, which is a process of assessing the implications for women and men in all areas and at all levels of actions taken (Hannan, 2001). For gender mainstreaming to inform policy, gendered data collection and analysis is needed that describes the involvement of men and women in areas of interest, such as reproductive health.

Without proper data on the issues related to males and females, it is not possible to make sound decisions. It is crucial that sector-specific gender related issues are dealt with in Botswana.

**Historical changes in approaches to gender**

Although gender mainstreaming became a key strategy for promoting equality between men and women after the 1995 Beijing Conference on Women, different eras have focused on and addressed the issue in various ways.
The awareness of the differential involvement of males and females in societal issues began some decades ago when it was realised that female participation in development endeavours was restricted. However, the limited participation by women was not of major concern, as women were regarded as passive beneficiaries of development. Their major roles were domestic in nature, as they related to motherhood and child bearing (Snyder & Tadesse, 1995). It was assumed that to enhance their roles in the domestic sphere, women needed to be provided for. This resulted in the welfare approach of the 1950s.

This strategy changed during the United Nations Decade for Women (1975–1985) as it became increasingly clear through sensitisation and lobbying that women were not passive recipients of goods and services, but that their roles went beyond the domestic sphere. Thus, through the works of other women, it became clear that women were an integral part of the production of the goods and services they consumed.

Around the same period, high population growth rates were perceived to be a major problem, especially for developing countries. The high population growth rates were associated with high fertility rates. Since programmes on fertility targeted women, it was assumed that improving women’s education, providing them with the requisite family planning services, and having them employed outside the home were important, not only in enhancing their own quality of life but in lowering the rate at which populations were growing. This realisation led to the change in the mindset of policy makers: the focus now was on the involvement of ‘Women in Development’ (WID). During this stage, the entry point of women in different activities had to be specified. The focus was always where the women were, or how the activity would benefit them. Men were never directly catered for. As a result of this targeting system, projects were silent on the reproductive roles of males, even though men were the main decision-makers in issues of reproduction.

The Women in Development approach resulted in a focus on maternal and child health. Family planning programmes were designed to satisfy the needs of women. As had been the case of the previous welfare approach, the Women in Development approach had no gender analysis pointing to the reasons for the existence of inequalities: that they existed as a result of the different roles ascribed to men and women. The interest was in providing greater opportunities to women who had been sidelined for a long time. In recent years, and as a result of high mortality rates due to mother-to-child HIV transmission, most programmes to prevent this form of transmission still focus on women.

The Women in Development approach left almost half of the population of the world out of development projects. The focus on one group undermined the fact that both men and women are part and parcel of societal expectations, and that any
programme that was not sensitive to the fact was bound to fail, due to differential targeting. This realisation and the fact that males were not sensitive to the issues that affected the population at large, and that projects were failing, led to a shift from women being the main focus, to an exploration of the nature of socially determined relationship between men and women. Specifically, the intrinsic roles of men and women were examined and found in fact to be societal constructions of what men and women ‘should’ do. It was determined also that these roles were not static, that they changed over time, and that they varied from one society to the next.

This realisation led to the third stage with a focus now on issues of men and women as they participate in the social, economic and political spheres. This became the starting point of the Gender and Development (GAD) approach: gender analysis became an integral part of assessing development issues. However, even with the Gender and Development approach, issues of reproduction and reproductive health still to a large extent continue to focus on women, thus the need to focus on males’ involvement in sexual and reproductive health.

Equality and equity
Equality in gender data analysis does not refer to equal numbers of men and women since it is well known that there is hardly any society that can boast of equal numbers of females and males. For one reason or another, there is always a bias in the sex ratio. The numbers of males and females in any community depends mainly on the levels of mortality and migration and their sex selectivity.

Equality does not mean treating men and women the same, because the two have differing gender and sex roles. Gender equality implies a favourable environment where men and women are able to live equally fulfilling lives and have equal opportunities, and also the recognition that men and women have different needs, priorities and constraints. Along similar lines, equity implies fair outcomes where a conducive environment exists for men and women to live equally fulfilling lives, have equal opportunities, recognising that men and women have different needs, priorities and constraints.

In this regard, it is possible to have female-only or male-only projects, because men and women have different needs, priorities and constraints. Because women’s gender roles as the primary caregivers for children and families involve them in a large amount of unpaid family and household work that affects their ability to participate in other activities, such as education, paid employment and decision-making, policies and programmes may affect women differently. These women may not have sufficient time resources to benefit from programmes that specifically target women.

Specifically, it is important to formulate concepts and definitions used in data collection that adequately reflect the diversity of women and men and capture all aspects
of their lives. The development of data collection methods should be able to fully reflect stereotypes and social and cultural factors that might produce gender biases. Only when these are fully understood can a case be made for the involvement or non-involvement of one group over the other in an activity, especially on reproductive health.

**Gender issues in Botswana**

The involvement of men in sexual and reproductive health is not the only gender concern in Botswana. The country has a number of other gender-related issues. The Dakar/Ngor Declaration and the ICPD Programme of Action first articulated these issues, which are cited in Government of Botswana & UNFPA (2003) as covering the following five areas:

- promotion of gender equality
- promulgation of national laws to eliminate all forms of discrimination against women
- provision of basic education for girl children
- increasing participation and promotion of women in sustainable development; and
- gender analysis and its role in social and demographic processes.

Apart from these long-standing areas of concern, most countries' gender development strategies are guided by the Millennium Development Goals. These are a set of eight goals developed by 198 United Nations member states, including Botswana, at the 2000 Millennium Summit of the United Nations. The Millennium Development Goals have set in motion a need to address the crucial challenges of global society. These goals clearly spell out what each member state should do to eradicate the many dimensions of poverty and to achieve sustainable human development.

Associated with these goals are sets of 18 targets, together with 48 assessment indicators, which are to be used to monitor and evaluate progress towards achieving the targets. All 18 targets are to be achieved by the year 2015. The Millennium Development Goal number three focuses on gender issues and stresses gender equality and women empowerment. The goal indicators that are to be used by different countries to assess gender equity are provided as follows:

- ratio of girls to boys in primary, secondary and tertiary education
- ratio of literate females to males of ages 15–24 years old
- share of women in non-agricultural employment
- proportion of seats held by women in national parliament.

In Botswana, at policy level, there seem to be no major gender disparities, as most of the laws that were deemed gender insensitive and that affected the rights of women have been amended. Among these laws are:
The Public Services (Amendment) Act 2000, which now includes issues of sexual harassment.

The Affiliation Proceedings Act (Amendment) Act 1999. The Act has been amended to promote gender equity. The amendment changed the term ‘mother’ to ‘parent’.

Sections 141 and 142 of the Penal Code (Amendment) Act 1998 made the definition of rape gender neutral, and recognised that both men and women can be raped.

The Employment (Amendment) Act 1996 provides women with the freedom to work underground in the mines.

The Citizenship (Amendment) Act 1995 allows children to acquire Botswana citizenship through their mothers as well as through the fathers. (Republic of Botswana & UNFPA, 2003)

While the amended laws do not directly address issues of reproductive health, they are aimed at underscoring the fact that issues of reproduction should focus on both women and men.

In terms of behavioural aspects, there are still some gender concerns that need to be addressed. These are discussed below according to the sector they are associated with.

1. **Teenage pregnancy** and its consequences on the health of women including the impact of their future development.

2. **Reproductive health**: There are several issues here. The first is related to the high rate of teenage fertility and the vulnerability of women to sexually transmitted infections, including HIV and AIDS. The second aspect is that most reproductive health programmes that have been put in place target women. Not much is known about men’s reproductive health needs. As a result of civil society organisations’ call for male involvement in reproductive health, males have recently been brought on board on programmes like Men, Sex and AIDS. Third, professions such as nursing are dominated by women, making it difficult for men to open up to them at times.

3. **Violence against women**: Gender-based violence, or violence against women is a major public health and human rights problem throughout the world. It has been suggested that violence against women has profound implications for health. According to WHO (2008): ‘...one of the most common forms of violence against women is that performed by a husband or male partner.’ This type of violence is frequently invisible since it happens behind closed doors, and in most cases, legal systems and cultural norms do not treat it as a crime, but rather as a ‘private’ family matter, or as a normal part of life. When it is treated as a crime, the
perpetrators often go unpunished as the victims usually withdraw the case for fear of societal scorn.

**Education:** Botswana is one of few other countries where the female literacy rate is higher than that of males, and the girls’ enrolment rate, especially at primary level, is higher than for boys. Despite this, females have not been able to capitalise on their early advantage of outnumbering males when it comes to science-related subjects, in which males dominate. The 1995 Policy on Women and Development recognised that female enrolment at both primary and junior secondary school levels was higher than that of males. However, this advantage decreases by the time pupils reach the last year of senior secondary education, with males having an advantage over females. The policy is concerned that the advantage of females over males in the educational system is confined to levels where education is not a significant stepping-stone into any job market (WAD, 1995). The analysis also shows that prior to adolescence, males and females perform equally well in science, mathematics and computer science. However, as girls enter adolescence, there is a high level of dominance of males in the fields of science and technology, as a large numbers of girls tend to lose interest in these subjects. As a result, at tertiary institutions, in the Faculties of Science and Engineering, female students made up 26 and 12 percent respectively of the students enrolled in 2002, and 60 and 57 percent of those enrolled in the Faculties of Humanities and Education respectively (CSO, 2002).

**Socially:** Regardless of the government position that every person is equal before the law, there still exist some societal expectations that women behave in a particular way, especially in relation to caring activities. Women are generally concentrated in socially-oriented committees, such as home-based care or village development committees, as opposed to financial committees, where men dominate.

**Poverty:** It has been established that female-headed household are more vulnerable to poverty than male-headed households. The main reasoning behind this is that generally females work in low paying jobs compared to their male counterparts, and yet they head relatively large households. For example, the 1991 census estimated that the average household size for males was 4.5 members, compared to 5.1 members for females. Ten years later in 2001, the average size of male-headed and female-headed households was about 3.5 and 4.6 respectively. Given the low paying jobs for women, it follows that per capita income for individual members of households headed by females is much lower than that of male headed-households.
Economically: In terms of employment and earnings, females tend to occupy low paying jobs, reinforcing their relatively weak economic status compared to their male counterparts, a situation that is said to be responsible for their vulnerability to HIV infection (Fidzani & Mukamaambo, 2001). The weak economic status facilitates their subordinate positions, lack of resources, vulnerability to poverty, and most importantly, their vulnerability to gender-based violence. Their relative weak economic status disempowers them, and their ability to negotiate for safe sex.

Data gaps: There is not the same amount of knowledge relating to the reproductive health needs for males and females, especially regarding males’ responsibility in women’s fertility decisions. With little involvement of women in development issues, in the past, it was men who defined the data needs issues that society considered sufficiently important. This led to the collection of data that was of greater importance to men, and which related to men’s traditional gender roles, particularly men’s economic roles. Even demographic data that appear to relate to women’s fertility were collected primarily to measure the size and composition of the population in order to provide input to the size of the economy, national product and national income (Hedman, 1996).

Sources of gender-related data in Botswana

There are five major data collection systems that produce some indicators on the population situation of any country, including Botswana. Even though they do not focus on reproductive health per se, the indicators taken from the sources can assist in assessing the situation of males and females in the areas of data collection, which can then be used to assess the economic status of males and females and thus their potential to access reproductive health facilities. The sources are:

- population/agricultural censuses
- sample surveys
- the System of National Accounts
- sentinel surveillance surveys
- official hospital records.

Based on these sources, areas that produce data include the following:

- Population size, composition, characteristics and distribution: In this area, it is possible to have indicators classified according to males and females.
- Families and households: multiple roles, poverty, fertility, mortality: Indicators classified by males and females are also possible in this area.
Gender Research: The Importance of Data Collection and Analysis of Male Involvement in Reproductive Health Issues

- **Work – equality (opportunities) and equity outcome of opportunities**: While it is possible to establish who is working and where they are working, it is not always possible to establish the outcome of the opportunities for males and females.

- **Economy – access to resources**: While it is possible to have a feel of the level of access to resources among males and females based on experience, the data collected is usually too aggregated to establish who owns what. For example, although the 2001 Census in Botswana contained a question on assets in the household, the unit of analysis was the household, not the individual males or females in the household.

- **Education – differentials and literacy levels**: There are two sources of data for this aspect, the censuses and official educational records. It is possible from these to have indicators classified according to males and females.

- **Health**: It is possible to have data collected on the distribution of males and females, including information on in- and out-patients. Reproductive health information is mainly provided for females.

- **Decision-making**: It is possible to have gender disaggregated data at policy level, but at household level it is not possible to do so as in most cases there are no targeted surveys on decision-making.

- **Environment preservation and degradation**: This is another area of interest. However, to date there are no data on the contribution of males and females to environmental degradation or regeneration.

Data available since HIV became known in the early 1980s was based on blood tests, which could only be done under clinical conditions. As a result, it had a limited use for the majority of data-collecting institutions, such as national statistics offices. The late 1990s saw additional HIV tests becoming available, among them the saliva test, which was recommended for use in household population related surveys.

The saliva-based test was used for the first time in a large-scale survey in Botswana during the second Botswana AIDS Impact Survey (BAIS II) in 2004. The result of the survey provides information on the HIV prevalence rate among males and females at the aggregate levels such as age, sex, occupation and many others. However, by its nature, the household HIV test as used in the BAIS II may not be of much use at individual levels as it does not have an inbuilt mechanism for call backs, or even to provide the survey population with feedback on their HIV status. Considering the coverage, and despite these limitations, this type of survey could be of more value than the traditional sentinel surveys. This is because it has an inbuilt ability to be representative of the total population since it uses proper statistical sampling procedures, even though these are costly in terms of money and time.
Voluntary HIV testing centres as sources of information on HIV have been established across the country. The centres have the potential to provide information on HIV status for males and females, including their reproductive health needs, as the information is collected with the full consent of those who seek services at these facilities. The limitations of this source are that not many people go for voluntary testing due to the fear of knowing their status, as well as the stigma that still exists towards people living with AIDS. Also, the testing patterns of individual men and women are not known.

Apart from some HIV data, most of the data directly or indirectly relate to reproductive health focus on women. As male reproductive health issues have been given minimal attention, not much is known about them. Moreover, men hardly ever get involved in their spouse’s reproductive health seeking activities, mainly due to cultural barriers. In the era of HIV and AIDS, this can no longer remain the status quo, especially as studies have shown that HIV is related to issues of reproduction, gender-based violence, and the status of women in general and their relatively weak economic status in particular. With this background it is essential to collect data that is disaggregated by gender. Where such data are not available, efforts should be made create them.

**Importance of gender disaggregated data**

According to Demissie (1998), the value of data can be determined and calculated from the activities and operations that are involved in generating them. Accordingly, he pointed out that the value of data = cost of the data-collection process + wages and salaries + data processing + printing + office accommodation and utilities + all other expenditures not classified elsewhere. Using this formula it becomes clear that data are a very expensive resource. Their expense is, of course, offset by their appreciation and usage. But because it is an expensive process, data should be collected in stringent circumstances and in such a way that they serve the purpose for which they were collected. Their use depends on their presentation, the target group and the focus topic. Users should be able to use the material with understanding.

In most cases data are used for acquiring facts or information from subjects for the following reasons:

- to provide an inventory of the situation at the time of data collection
- to update existing data on a regular basis and to provide time series data over time
- to evaluate and monitor the impact of various activities undertaken within the components of national socio-economic programmes
- for management purposes
- for operational planning
to be used in marketing.

Where there is no data or no reliable data these activities cannot be performed. If they are enacted without data, it is very likely that incorrect inferences and conclusions would be arrived at.

The importance of gender disaggregated data gained momentum in the early 1980s as a result of the shift of focus from the ‘Women in Development’ approach to the ‘Gender and Development’ approach. These changes were expressed in all areas of data collection, especially regarding demographic characteristics. Data collected on reproduction and reproductive health still lagged behind, probably because of the biased nature of fertility and health surveys that have always been female oriented. Most surveys on HIV and AIDS have women as the main targets. Data collection and analysis for population and housing censuses, which provide important benchmarking for analysis, are usually disaggregated by sex. Not much is done to disaggregate information on males and females in a number of fields, such as of males and females in the National Accounting Systems, or to assess the gendered impact of international trade or trade policy processes, or even the economic decision-making power within government, the private sector as well as at household levels. Trade policies, for example, may have gendered impacts and outcomes on reproduction and reproductive health, especially where there is increased feminisation of labour force participation.

In relation to population issues and the need to streamline population and development, the programme of action adopted at the end of the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, moved away from the family planning approach of influencing fertility, which had been the focus of previous international population conferences, to a reproductive health approach. Women were once again the main targets of the programme of action, as had historically been the case since they are easier to reach through their reproductive health seeking behaviour at antenatal clinics or at family planning services. In contrast, males mostly acquire male condoms without consulting health personnel, as they do not need any particular clinical assessment. This denies males an opportunity to provide data. In addition, females can also collect condoms for males, regardless of their relationship.

The most common presentation of data is the format of showing men and women side-by-side in a table or graph, without a common denominator, as there are not equal numbers of men and women. Thus, the sex ratio is not always 100. Even when it is presented as 100 males for every 100 females, there would be socio-economic reasons for the distribution.

Usually population data is collected according to sex, the biological attribute of a male or a female, and tabulated using the same. In the absence of any gender bias, there should not be any systematic disparities between the distribution of males and females.
with regard to a particular characteristic. The distribution of males and females should reflect random variation and not systematic ones. Thus, where there is a systematic tendency of females to belong to one particular category and males to another, the only plausible explanation would be the influence of gender-related stereotyping, and society’s expectations of males and females. It is when there is a clear systematic tendency of females to belong to one group and males to belong to another, that gender analysis studies become important. It then becomes necessary not only to tabulate the data according to sex, but also to conduct an in-depth study and analysis on the views held by men and women to assess if the prevailing differences in socialisation influence the choices made.

According to the World Health Organization (2008b), reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide whether to get pregnant, when, and with what frequency. Implicit in this statement is the right of men and women to be informed of the availability and accessibility of safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. With the advent of HIV and AIDS, reproductive health needs to go beyond the fertility needs of individuals to include the responsible sexual behaviour (knowledge, attitudes and practices) of both males and females.

Furthermore, despite females being regarded as more vulnerable to HIV and AIDS (justification for the attention they get), it has been found that even though the general prevalence rate for females is higher than for males, there are areas where males’ prevalence is higher than females’. For example, in Botswana, the age–sex prevalence rate between 15–39 years favours women, but males dominate females in terms of prevalence in the 40–49 age group. In relation to marital status, the data from Lesotho indicate there is statistically significant dominance of prevalence in males over females for individuals either in marriage or in some union, while the converse holds for unmarried individuals. Also, males’ knowledge about HIV and AIDS issues is significantly lower than that of females, and their behaviour is riskier than females shown, for example, by their persistent refusal to use condoms and to go for voluntary testing (Mutabihirwa & Mukamaambo, 2007).

Gendered data is used to describe statistical compilations of facts related to women and men in a country or locality. It underpins and informs good policy development, especially on the situation of women and men in a country. To this effect, Hedman (1996) stated that:
1. All statistics on individuals should be collected, collated and presented *disaggregated by gender*.

2. All variables and characteristics should be *analysed and presented with gender as a primary and overall classification*. This means that it is not sufficient to present just one table showing the situation disaggregated by gender. All tables of individual-level data – population by education, labour force by occupation, economic activity etc – must be disaggregated by gender in addition to all other variables of interest.

   Specific efforts should be made to identify gender issues and provide data that address these. The Commonwealth Secretariat’s 1979 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) also recommended the generation of gender sensitive indicators to provide good baseline data on the situation of men and women. Furthermore, the Beijing Platform of Action (1996) recommended that all women’s national strategies must be informed by clear analysis of gender gaps and disparities. Such disaggregated data would be used to monitor performance towards achieving the goals alluded to previously, as well as to identify improvements or for evaluation purposes.

**Reproductive health indicators**

Reproductive health indicators are the data that are necessary for planning and managing reproductive health programmes. They are used to assess the needs of programmes, monitor progress and evaluate programme implementation and impacts. The World Health Organization (1997) recommended that for an indicator to be useful it must have the following attributes:

- It must be a yardstick to measure progress towards attaining improved reproductive health status.
- It must be valid and sensitive to what it is expected to assess.
- It must cover all the important issues of the target population.
- It must be simple and easily understood.
- The data required must be easy to assess.
- Data collection for the indicator must follow ethical principals of confidentiality, informed consent, etc.

**The situation in Botswana and recommendations for policy**

In terms of reproductive health, although the policies and structures in Botswana are currently gender neutral, the generation of data and information to support the implementation, monitoring and evaluation of the associated programmes has been
biased towards women. While male involvement in reproductive health has been identified as a necessity, a more systematic process of collecting such data is still at its formative stage. The statistical indicators to monitor males’ involvement are scarce. For example, until recently, the sentinel surveillance on HIV and AIDS had been centred on women reporting to clinics for antenatal services. This could be arising mostly from the notion that the rate of HIV infection in pregnant woman has been shown to be a reasonable proxy for the level in males and females combined (WHO & UNAIDS, 2000). The gender imbalance on HIV and AIDS issues is also echoed by UNAIDS (2002:11) in Guideline 8 on HIV and AIDS and human rights, which single out women as one of the vulnerable groups. In Botswana, most surveys incorporating reproductive health, such as the Botswana Family Health Surveys and the Botswana AIDS Impact Survey (BAIS) series, tend to focus on women and their sexual history; an observation emphasised by Doehlie & Maswabi (1998), who hold that while men are often assumed to be responsible for the dramatic spread of HIV and AIDS, very little has been done to research male sexuality. Maundeni (2004) has noted that in order for HIV strategies to have a greater impact, there is a need for both research and programmes that target males. This scenario of gender imbalanced data collection could lead in turn to policy decisions tending to be either gender biased towards women, or strategically gender neutral.

In its mission to reduce poverty and make sustainable development possible for poor women livestock keepers, the International Livestock Research Institute (2008) points out the importance of collecting sex-disaggregated data to:
- increase the understanding of the different roles of men and women in any activity
- identify potential barriers to male and female initiatives
- understand gender differences in accessing information sources and services, and in participating in social networks; and
- to assess opportunities to enable men and women to have equal opportunities to participate in development activities, and to contribute to the knowledge base.

**Conclusion**

This chapter discussed the importance of gender research. It established that most data, especially on fertility and HIV, target women. This is so largely because of females’ reproductive seeking behaviour at antenatal clinics. Little is known about the reproductive health needs of males. The main recommendation is that both men and women need to be catered for in reproductive health services. However, instead of the blind provision of these services, there is a need to target gender research to establish the existing societal gender expectations that are likely to impede the involvement of
both men and women in reproductive health issues, as well as establish reasons for non-male involvement. This information would inform policy.

References
Gaborone: AIDSSTD Unit, Ministry of Health.


Chapter 11

Transformations in Gender Roles and Relationships:

Impact on childcare and socialisation

Motshedisi Boitumelo Sabone
Social mobility and changing gender roles and relationships disturb the critical role of families in socialising children. In the traditional set-up, every elder had a role in socialising children. The kin network ensured that every child was orientated to the value system that not only sustained the group, but also identified the group. With urbanisation and modernisation, the threads that used to link the extended family system or a community of people who share a common culture have been weakened. Also, the changing roles of men and women and how they relate to one another have made communication between generations complex.

However, the family remains an important institution for socialising children. It is therefore important that men and women who advocate for change, those who promote the emancipation of women and for balancing of rights of men and women, girls and boys, pause to consider how these changes impact on children, who are the future generation.

This chapter examines the extent to which child socialisation has been taken into the agenda for transforming society. This is done by examining the roles of men and women in childcare. The idea is to stimulate readers to reflect on the extent to which men and women play their respective roles in childcare and socialisation. Attention is also focused on the reasons why females are more involved in childcare than their male counterparts. This is followed by an argument for partnership between men and women in childcare and socialisation. The last part discusses implications of the study findings for counselling, research and policy, as well as recommendations.

The roles of men and women in childcare and child socialisation

The chapter is based on a study that aimed to explore the experiences of men and women in relationships in rural and urban Botswana. In-depth interviews were conducted with six men and seven women purposely sampled from rural (Molepolole) and urban (Gaborone) parts of the country. Those selected were willing to engage in discussions addressing the research question. The lives of men and women in the household, at the workplace, and in the community in general were explored. The focus was at family level.

The research findings revealed that women were more involved with children than men. It is important to examine the structures or systems that justify or support the state of affairs. As women increasingly participate in formal employment, and couples
have fewer children, one would expect that things would balance themselves out in such a way that women would have a reduced load of household work, including childcare, while men increased their share in such roles. This is not the case.

The same observation – that wives are more involved with children than husbands – has been reported in many other cultures, including those in developed countries where there is a longer history of women’s participation in formal employment than in developing countries (Cinamon & Rich, 2002; Hossain & Roopnarine, 1993).

That women mostly provide care to children is consistent with stereotypical gender roles. In cases where men do perform childcare activities, it is in response to family emergencies, especially where the wife is deceased or ill. In one interviewee’s case, the man was more involved with the children than his wife because she had a chronic illness. He took over the major responsibility and day-to-day tasks for the children and continued to perform them even after she recovered from her illness. Consequently, in this man’s family, the children were closer to their father than to their mother, who, according to the husband, was insensitive to the children’s needs. The man felt that there was nothing difficult in doing childcare, and that all one needed was exposure and experience. However, the man did report that he engaged his daughter in household activities to a greater degree than his sons. The daughter would be helping her father with household chores while the sons had ample time to do their schoolwork.

The situation of this man cannot be taken as a sign of men’s inclination to assume non-traditional gender roles for several reasons. First, the newly assumed roles are taken together with the stereotypical male roles, that is, the latter are not transferred to the female figure. Secondly, the man’s mindset is still orientated towards stereotypical gender roles as evidenced by the tasks that he assigns to the girl and boy children. One can, therefore, argue that stereotyped gender roles can be assumed by another gender in the event that the rightful gender is not available. This is an indication that gender roles are flexible, and can be manipulated for the convenience of those who enact them.

Risman & Johnson-Sumerford (1998) note that the type of situation described above comes about not by choice, but because of events beyond the control of the man. In fact, the way the man interacts with his children gives the impression that even though he is doing what is normally viewed as a woman’s job, he did not see it as normal: if he had the choice, he would not do it.

Is it equally easy for a woman to switch into a man’s role if circumstances demand it? Another interviewee was a single mother raising two boys on her own. This case suggests that women can assume stereotyped men’s roles. The woman reported that she performed tasks such as repairing household appliances. She described how a man saw her assembling her son’s new bicycle, and wondered how she managed to
do that as a woman. She reasoned that there was nothing difficult in assembling a bicycle if one read instructions. The woman was exposing her sons to all kinds of roles because, she explained, they had to be prepared to do any type of job should they not find careers of their choice. This woman’s story also provides evidence for flexibility of gender roles when people are faced with situations where the other gender is not available. Even as a single mother, the message she was passing to her sons was that they should follow men’s traditional career paths; if that was not available, they would be justified in taking a woman’s career. The two cases show that both men and women participate in the perpetuation of gendered roles in socialising their children.

It can be argued that the likelihood of a father assuming childcare and sustaining it depends on whether the mother or mother figure remains unavailable. The following observations justify this position: It was only in households with both male and female parents that respondents were adamant about the fact that women should take care of the children. Moreover, where a mother substitute could be found, the man did not assume childcare. One rural man had his mother take care of the children after his wife’s death.

Finding a mother substitute is easier in rural areas where the kin network is available than in urban areas where people in a neighbourhood are more or less strangers. However, the fact that men in Gaborone were not different from those in Molepolole with regard to the level of participation in childcare suggests that the place of residence alone cannot be said to be a strong determinant of men’s participation in childcare and child socialisation, at least not as strong as the absence of a mother or father figure.

Subtle differences could be discerned in rural and urban residents, however. Women in Molepolole were not as concerned about men participating in childcare, as those in Gaborone. They were content for their male partners to provide money to facilitate childcare.

With regard to the tasks that they allocated to their male and female children, rural women assigned household chores to both boys and girls. However, for male children, that was only temporary because as they matured, they were expected to leave the home and be exposed to male roles outside the home. One rural woman from Molepolole had this to say:

When they are still young my male children help with household chores such as sweeping the house and doing the dishes. As they mature, however, they leave such tasks to their sisters and go out to take care of livestock and to do other manly assignments.
Urban parents believed that it was not wise to channel children into doing male or female tasks; mainly because employment opportunities for the youth were increasingly becoming scarce, necessitating that young people be prepared to take any job offer at their disposal, regardless of it being associated with the male or female gender. They noted that even if they had wished to assign tasks by gender, that would be difficult in the case of male children because fathers would not be able to role model traditional male roles, such as farming and other physically demanding tasks.

Why are women more involved with children than men?

Some male participants in both Gaborone and Molepolole reasoned that they left the childcare to their wives because they were good at it or because that was just the way things had unfolded. They reported that whereas men tended to take children’s questions and demands less seriously, women give them the seriousness they deserve. As one put it: ‘Women have time for the children.’ The result was that children tended to take their mother’s opinion more seriously than their father’s.

The men felt that children needed to be understood but that fathers did not have the patience for this. The men said that while women are able to chat and smile with children, men are not good at that. That, nonetheless, did not mean that fathers did not love their children. One urban man from Gaborone observed that the Setswana culture contributes to alienating fathers from their children. He asserted that children were initially kept away from their fathers, and only introduced to them later in their lives. He gave as an example the fact that childbirth is only witnessed by women. He related an incident where he had travelled several kilometres to a rural area in order to see his newborn baby, only to be told by his mother-in-law that he could not see the baby.

Another observation was that naturally children are close to their mothers. Therefore, it was not because of any person’s deliberate effort that children were closer to their mothers than fathers. One man had this to say:

My children are closer to their mothers, but I did not create it. I just found it in place and I also experienced it when I was a child. Even when I wanted to get married, I did not tell my father. I told my mother, who later told my father…. Of course sometimes it makes me feel bad when I spend the whole day with my children and they have pressing needs that they do not express until their mother arrives.

Although women felt that men were not doing enough in childcare and other household responsibilities, some men felt that women had it hard with children because they were unnecessarily over-involved, that somehow they chose to be in
that type of situation. The following is a sentiment expressed by a man from an urban dual career family:

"At times we need to sacrifice if we are to achieve what we want. Somehow women do not let go some of these things. It is not that men do not care, nor is it because they do not love. Perhaps the problem is that they do not show it. As we speak, my wife is taking evening classes. I encourage her to take her time instead of rushing home after work, but that seems to be difficult for her. Women must learn to temporarily put aside children and attend to themselves.

From the responses of men and women participating in the study, one can argue that men and women co-participate in creating situations where women take the largest share in childcare. They do that because it is the reality that they have known. In other words, ‘reality is what one sees, hears, feels, etc’. Therefore, participants believe that women should take care of children because that is what they have seen in socialised gendered roles. This perception is congruent with what one participant from Molepolole gave as a reason for her perception that the role of men in society is to lead. In her words:

"Men are leaders because we find them in leadership positions in areas such as chieftainship, politics, and religion.

Because women are closer to children than men, they understand their language better and can communicate with them better, and are thus better able to meet their needs. Perhaps when men realise that their performance at childcare is not as good as that of women, they retire, and leave the entire childcare responsibility to women, who in turn further refine their skills while men become even more alienated from them. The status quo is, therefore, perpetuated. Women can thus be seen as a group trained to take care of the children, while men are untrained. The respondents argued that with exposure and experience, men could become as good as women at childcare. The case of the man who assumed a large share of childcare and became closer to his children when his wife became sick provides evidence to support this argument.

Gilbert (1998) observed that values that men and women bring to the family partly influence the husband and wife’s involvement with the children. He argued that many women continue to be socialised into believing that being a wife and raising a family are the main priority in life, and that financial independence and career advancement are secondary. This may explain why one man in this study whose wife also had a career argued that women were partly to blame for their childcare-related strain, due to the priority accorded to child rearing at the expense of a formal career. In the same
vein, it may explain why a dual career woman observed that men think that their work is more important than women’s, and that their career advancement is unhampered by childcare and other household chores.

The strain of childcare and housework

Women from both Molepolole and Gaborone reported that childcare was a physically and emotionally draining undertaking. However, because childcare was intertwined with other household work, it was difficult to examine childcare as a distinct entity. Women observed that the burden of childcare, coupled with household work, could leave one exhausted. Even when there was a paid home-helper, women still suffered role strain because it was they who supervised the helper. This role strain was particularly felt by urban women, who had in addition to childcare and household work, formal employment, educational commitments, or both. They noted that often because of a lack of time, they found themselves neglecting responsibilities they wished to fulfill. For instance, one Gaborone woman said that she could hardly find time to invite a neighbour for a cup of coffee.

Men did not experience any role overload. Women stated that role strain could even make a woman lose interest in sex, in which case the husband would take it as an excuse for extra-marital affairs. It could also interfere with women’s career advancement.

A Gaborone woman expressed these sentiments:

Like everybody else, I wish only the sky could be the limit, but being a woman, this is hard to achieve because of pressure at home… A man can afford to go straight from work to the library, whereas a woman will have to rush home first to check how the children are doing... Being a wife, mother, worker, and student can be hectic… Role overload could lead to temperament to the extent that one may not even enjoy humour. One may be irritable when she or he is tired and the child wants to play.

Discrimination of children on the basis of their kinship increases the strain that women experience. Mothers reported having to act as a shock absorber to shield the children from abuse from mothers-in-law. The tension that frequently existed between mother-in-law and daughter-in-law could be transmitted to the grandchildren, that is, the daughter-in-law’s children. Some women had a strained relationship with their mother-in-law and were concerned that their mother-in-law was discriminating against their children by giving preferential treatment to the daughter’s children. They felt that those grandmothers felt closer to their daughter’s children and treated the son’s children like strangers. None of the male participants experienced the discrimination of children alluded to by female participants; nor did any of them report role strain.
It was evident that even though women had a larger share of childcare than men, they did not always have the authority that went with the responsibility. Even though women’s contribution to childcare may be highly valued, they may still be treated as minors when it comes to major decisions relating to the welfare of children. A rural woman related an incident where another woman was taken to the traditional court to be reprimanded because she had consented to the medical treatment of her child in an emergency situation without the knowledge of her husband, who was absent from the home at the time. The woman had to pay a penalty despite the fact that the treatment had been successful.

In their study on the importance men and women attach to work and family roles, Cinamon & Rich (2002) observed that women fitted a ‘family profile’, while man fitted a ‘work profile’. However, if women were in managerial (demanding) positions, they were equally as concerned about work as men, the only problem being that they were unable to give the same commitment to their work as men. This suggests that if women had the time, they would attach as much importance to work as men, and possibly advance their careers as much as men.

**The need for partnership between men and women in childcare**

Women participants in both Molepolole and Gaborone expressed a concern over the low involvement of men in children’s lives. They saw a need for a partnership in raising children. The pressure was not so much on the perceived need for both mother and father figures, but was more of the wish for men and women to share the burden of childcare. For rural unemployed women, the man’s role was viewed more in terms of provision of material welfare, such as food and clothing for the children. A man was expected to work and support his children.

It was interesting that urban women demanded men’s active involvement in childcare in contrast to rural men and women, as well as urban men. One would expect that urban men and women would hold similar views about the parental contribution to childcare, when one considers the fact that both men and women are in formal employment. But urban men saw children as women’s business. They saw their role as making sure that material resources were available for the welfare of children. A married man from Gaborone said:

*I have given my wife all the responsibility over the children. I expect her to inform me if the children are sick or if there is anything that they need.*

One can argue that the pressure of urban life seems to influence women to reconsider how husbands and wives share childcare so that the burden of care can be
evenly distributed between the two parties. However, men have not really felt this pressure, at least as far as childcare is concerned. The participation of women in formal employment has not really changed the way men look at childcare and the role of men and women. There was no indication that respondents ever paused to think about the impact that their interaction with their children, or the decisions that they make about their children, may have on their growth and development.

Even the concerns raised by women are limited to the practical aspects of childcare such as help with schoolwork, feeding, and provision of essential necessities such as clothing. No mention was made of the psychological consequences of the parent who is physically there but missing in emotional connectedness. It must be noted, however, that both urban and rural women recognised that the strain associated with childcare may lead to problems in other aspects of a woman’s life.

It is important that men and women play their fair share in childcare and child socialisation. It has been noted that not only is the presence of both mother and father in the child’s life necessary for his or her emotional and intellectual development, but that it also presents an environment where he or she learns gender roles and begins to appreciate the other gender (Stanton, 2003b). It has been argued that those children whose mother and father were co-present in their lives have a better chance of a good relationship with their future spouses than those who had only one of the parents (Stanton, 2003a).

Paying attention to how we socialise children is even more important nowadays when risky behaviours such as alcohol and drug abuse, premature and unprotected sex, HIV and AIDS, partner murders and suicides have become rampant in our society. It is important that mothers and fathers communicate with their children to instil values and to guide them without being emotionally over-involved. As the saying goes: ‘There is power in numbers’ or in Setswana: setshwarwa ke ntša pedi ga se thata. We may be able to make a difference in helping our youth’s transition to responsible adulthood if we join efforts as men and women and as fathers and mothers. Not only are our young people in need of care and guidance, but they are also becoming parents at a tender age. Within the short period of their interaction with their parents, mothers and fathers should be positive role models, preparing their children to raise and care for their own offspring.

Conclusion and recommendations

Despite the fact that both women and men participate in formal employment now, women still take a larger share of the responsibility for childcare and socialisation. This state of affairs often brings about conflict in the family and may cause confusion in children. The findings of the study have important implications for family counselling. Counselling needs to recognise that both men and women are products of their
upbringing and social expectations. They therefore need re-education that does not put blame on any particular individual. With this in mind, they have to be assisted to negotiate roles and sharing of tasks without blaming one another, and create a home environment that is conducive to healthy children’s development.

Three recommendations are suggested, namely, family counselling, further research, and policy formulation. There is a need for shared childcare and socialisation responsibility for mothers and fathers, and this needs to be addressed in pre-marital and marital counselling, as well as family counselling. This is even more important for dual-career families. Perhaps families take it for granted that things will sort themselves out, but this is becoming more and more illusive because of the busy schedules that both men and women are faced with. Counselling needs to equip women with assertiveness and negotiation skills so that they can speak for themselves. It is women who feel the strain related to childcare, and they are the people who should spearhead the move to reduce the load on their shoulders. The critical point is that women need to be proactive in liberating themselves, because they are the people living their experiences, and counselling needs to encourage that initiative.

Counselling has to address the fact that child rearing should be planned in advance. We must appreciate the fact that children are able to capture even subtle nuances in their environment, and that they should never be judged too young to pick up what is happening around them. Marriage counsellors should, therefore, find out more about the relational pattern of the nuclear and extended family to assist them with how to get along with one another, and children could also benefit from the larger pool of support networks.

Future research on gender and childcare and socialisation should include children. We need to hear voices of children speaking to their experiences with mothers and fathers and what their needs are. Also, studies that involve couples could be illuminating, with the researcher going back and forth to check participants’ reactions to one another’s opinions. This constant comparison provides an opportunity to clarify what is observed or heard, like a dialogue. Focus discussions could also bring men and women together so that issues are debated and areas of convergence and divergence are identified and given appropriate attention.

Dialogues are important in addressing the issues related to gender because often two people may appear to be pulling in opposite directions when in fact each thinks what she or he is doing is in the best interests of the family. Dialogues could, therefore, clarify some issues and help men and women reach a compromise. Dialogues may simplify some paradoxes in gender role sharing and childcare. This study has a limited generalisation in that only a few men and women participated. Future studies could add a quantitative element to grasp the extent of the issues identified, and if
appropriate, be generalised to other settings. Quantitative studies could also help to establish causal links between phenomena.

Furthermore, the value of both mothers and fathers in children’s development must be evident at the policy level. What is required is the development of policies that encourage marital partners to live together. For instance, if job postings in the public service continue to disregard the family unit and the importance of partnership between husband and wife in child rearing, the message that this practice communicates is that one of the parents can manage alone, thus reinforcing the perceptions evident in this study. The employment policy must emphasise and encourage the posting of husbands and wives to the same geographical area. The value of husband-wife partnerships in childcare and child socialisation must be continuously reinforced through in-service education at the work place.

Even if governments may be making an effort to promote women’s careers and advancement to positions of authority, women will continue to lag behind because of the burden of childcare or ‘the pressure at home.’ It would be unfair for job performance appraisal systems to disregard the possibility that women’s work output may be affected by family demands such as childcare. There is a need for a system that will ensure that the targets that men and women set for themselves thoroughly consider how much each person is actually available for the job. We must recognise the fact that the roles that we play in families are as important as the services we provide to society. Obviously, the targets that employed women set for themselves and their career mobility will be compromised by the time they spend in childcare and even just being preoccupied with the welfare of their children. Women are less likely to travel and, therefore, less likely than men to be exposed to diverse environments important for creative thinking. Ultimately, the life goals that male and female children set for themselves reflect what they learned from their parents’ lives, and the cycle of men as high achievers and women as low achievers continues.

References

Towards Effective Ways of Involving Males in Sexual and Reproductive Health

Tapologo Maundeni, Bertha Osei-Hwedie, Elizabeth Mukamaambo and Peggy Ntseane

The central focus of the chapters in this book has been to explore the issue of male involvement in sexual and reproductive health, primarily, prevention of HIV and AIDS and gender-based violence. The common thread among the authors is the fact that male engagement in health programmes is critical to successful and sustainable outcomes. However, as underscored by all the authors, there is a lack of or limited male involvement. This is evidenced by the low numbers of men going for HIV testing, and PMTCT, and CHBC.

This is in spite of efforts geared to get males involved in reproductive health by both the government and NGOs, including male advocacy groups. Such minimal male involvement impacts negatively on women and undermines the government’s efforts to promote healthy livelihoods. The authors have identified, among other things, many challenges that hinder the active involvement of males in sexual reproductive health programmes in Botswana. These include cultural and biological factors, programmes biased towards women folk at the expense of their male counterparts, and unwelcoming (to men) health delivery system.

What remains unclear is how to overcome such barriers and formulate a national gendered approach to sexual reproductive health in Botswana for the effective engagement of males. The chapters in this book provide some of the answers to this challenge in the form of policy recommendations. In this final chapter, therefore, an attempt is made to draw out and solidify some of the (policy) implications arising from the chapters.

The need for research

Some chapters have demonstrated that some effort, albeit relatively recent, is being made to engage males in sexual reproductive health in Botswana. However, such a campaign is not nationwide and progress has been slow. This suggests that research in the area of male involvement in sexual reproductive health needs to be intensified to maximise outcomes.

Several areas which require scholarly attention include analysis of:
strategies aimed at increasing male involvement in sexual reproductive health programmes

direct experiences of males living with HIV

strategies aimed at addressing HIV related challenges faced by males

mens views of the causes of passion killings

the social construction of gender and masculinities.

The research should raise further questions about the interface between the impact of macro-level structural forces such as culture and the economy on sexuality and sexual behaviour, as well as the micro-level negotiations of sexuality, and their impact in spreading and reducing HIV in Botswana. Furthermore, there is a need to conduct a proper gender analysis in the context of Botswana to ensure that initiatives and programmes undertaken by the government and NGOs are based on facts and analysis rather than assumptions. This will not only pave the way for gender inclusive programmes and quality and effectiveness of initiatives but will also inform the formulation of relevant policy.

The need for reorientation in cultural aspects that relate to gender

While acknowledging the fact that cultural beliefs have deep roots and, therefore, are not easily amenable to change, the authors strongly believe in reorientation of behaviour as a long-term and sustainable solution. This is reinforced by the fact that cultural values and beliefs are dynamic and adjust accordingly to changing demands, in this case, the fight against the scourge of HIV and AIDS as well as gender-based violence. Cultural beliefs and practices, especially patriarchy, that portray males as superior to females as well as those that emphasise gender stereotypes need to be revisited. This is important because they put both males and females at risk of HIV infection and foster gender-based violence.

The need for interventions that are male inclusive

The fact that, to date, sexual reproductive health programmes have primarily targeted females suggests a need for a gender-balanced approach that involves both males and females. It also suggests that engaging men is not easy. However, the fact remains that interventions, by both the government and NGOs, that are male inclusive are crucial, but have to tread carefully. Male inclusive interventions should not undermine men, but should be user-friendly to them. Moreover, the type of language used should be directed at reorienting rather than undermining men. As Garegae and Gobagoba
in Chapter Three note, there is a need for a ‘sympathising heart.’ This requires all stakeholders to recognise, among other things, that engaging males on issues of HIV and AIDS is like rewinding the socialisation wheel, which will not take place overnight. It has to be a very engaging, long-term process.

**The need for lobbying and advocacy**

The contributing chapters acknowledge that the government cannot single-handedly promote sexual reproductive health programmes. The role of civil society is also paramount, especially in lobbying the government or any other health provider and advocating for all-inclusive programmes. Therefore, stakeholders concerned about gender issues should engage in more rigorous efforts to advocate for policies and programmes that favour males. In order for advocacy efforts of stakeholders to be effective, they need to take place over a continued period of time. Effective advocacy also requires strong and continued networking among stakeholders such as the Sexual and Reproductive Health Unit in the Ministry of Health, the Women’s Affairs Department in the Ministry of Labour and Home Affairs, NGOs, CBOs, gender focal points in sectoral ministries and male action groups. However, the ultimate aim of such lobbying and advocacy is to promote gender-balanced policies and programmes.

**The need to sensitise society about both gender-based violence and HIV and AIDS**

The gravity of gender-based violence as articulated by Moagi-Gulubane in Chapter Eight and the threat posed by HIV and AIDS necessitates a collective approach by the whole society if the battle is to be won. In this respect, intense campaigns that sensitise society (both males and females) about the benefits of male involvement in sexual and reproductive health matters, as well as the disadvantages of their inadequate involvement are crucial. Such sensitisation could benefit from targeting men due to their limited involvement in health programmes and matters. The campaigns also need to focus on the dehumanising aspects of gender-based violence. Such campaigns should be undertaken by both the government, especially local government (chiefs) and NGOs, as both have structures that reach the grassroots.

However, although NGOs are better placed than the government to undertake the sensitisation drive, they face a number of challenges. As mentioned in Chapters Two and Four, financial constraints limit the extent to which NGOs can extend their services to remote areas, therefore, they largely provide services in towns. Thus, there is a need to capacitate NGOs in terms of human resources and funds to enable the spread of their activities nationwide, especially to remote areas. Consequently, organisations driving campaigns against gender-based violence and HIV such as Emang Basadi,
BONELA, Ditshwanelo, and BONEPWA have a number of options in this respect. They could either embark on rigorous fundraising efforts so that they can roll out programmes to remote areas of the country, or solicit funds from donors, especially relating to gender-induced violence and HIV and AIDS, or seek financial assistance from the government of Botswana through appropriate ministries.

NGOs also have the arduous task of information dissemination which is crucial because it increases knowledge and can provide a platform for a change in attitudes, beliefs and practices about both domestic violence and HIV and AIDS. This is particularly true when participatory methods, such as group discussions, workshops, question and answer sessions, entertainment, role plays, drama and songs are used.

The need to reflect on gender-based violence as well as HIV and AIDS approaches

While the authors in this book acknowledge the tremendous efforts made by the government of Botswana and NGOs, through information and education communication to fight against gender-based violence and HIV and AIDS, there is a need for retrospection, evaluation and assessment to gauge successes and shortcomings. Specifically, there is a need for all stakeholders to assess messages about both gender-based violence and HIV and AIDS that are sent out to the public. For instance, are these the intended messages? How do males and females perceive the messages that they are receiving? What is the impact of such messages on males and females? Do the messages romanticise the role of male and female relationships without examining sexist practices that are usually subtly embedded in gender relations? What are the effective messages and ways of transmitting messages to the public – radio, television, billboards, drama or plays, etc? What role should chiefs play in crafting and disseminating messages to the public? Such evaluation and assessment would allow for the adoption of new, innovative and effective ways of crafting and disseminating messages.

The need for interventions that target males at an early age

In view of the recognition by all the authors that men are not involved or only minimally so in sexual reproductive health due primarily to cultural factors, it is our suggestion that programmes that empower the boy child about sexual reproductive health issues should be established at an early age. Such programmes will also give the boy child a chance to reflect on the potential negative implications and costs of traditional views of manhood.

The programmes could focus on issues such as communication skills, self-awareness and self-esteem, assertiveness, values identification, peer pressure, gender awareness
and equality, the gender-based responsive decision-making role, conflict management strategies, and puberty-related matters. It should be noted that currently almost all existing programmes that focus on challenges facing children and adolescents are unisex.

Unisex programmes are inadequate in terms of meeting the HIV-related challenges faced by the boy child because they do not seem to be cognisant of gender differences. Boys and girls have different life skills and sex education needs; therefore, these may not be adequately addressed in unisex programmes. Moreover, unisex programmes may be less beneficial to boys because boys rarely open up about their feelings.

The need for couples counselling
Although couple counselling is not commonplace in Botswana, in Chapter Five, Poloko Mmonadibe suggests it as a way of involving males in sexual reproductive health. Couples counselling has worked well in modern, well-developed countries, which could serve as a model for Botswana. Therefore, health service regulations and procedures that encourage people to access health services as couples, regardless of their marital status, should be established.

Such programmes could rely to some extent on peer counsellors. Peers may be more effective because they may be perceived as better understanding the issues or having greater credibility. Consequently, they make the educational process more accessible and less intimidating. Evidence around the world shows that peer involvement in prevention strategies can contribute significantly to the success of programmes.