A Historical and Gendered Perspective on HIV/AIDS in Botswana

Jan Hesselberg[a]
&
Anders Iversen[b]

Abstract

The article discusses the historical roots of the high prevalence of HIV/AIDS in Botswana. The point of departure is the debate on African sexuality. It is then shown that economic reasons that forced a large part of the men, and later also women, to engage in labour migration to South Africa and more recently to towns in Botswana, are probably the main explanation. The spatial splitting of households and partners for prolonged periods of time and the resulting multilocality of families is together with pre- and early colonial sexual norms contributing to an understanding of the present epidemic.

It is better to have unprotected sex, which gives you and your children food now and you die in 5 to 10 years, than to die of starvation tomorrow

(a woman in a city slum)

Key words: HIV/AIDS; gender; political economy; Botswana

---

[a] Professor of Human Geography, Department of Sociology and Human Geography, University of Oslo, PB 1096 Blindern, 0317 Oslo, Norway, jan.hesselberg@sgeo.uio.no, +4722855919

[b] Lecturer of Social Science, Faculty of Social Science, University of Oslo, Norway, iversenab@gmail.com

Introduction

The argument of the article rests on the view that non-use of condoms in heterosexual activities is the main immediate reason for the exceptionally high rate of HIV/AIDS in southern Africa, and that an early debut and parallel partners are contributing factors. The popularity of the pill among young educated women before and in the early phase of the epidemic was an important factor at the time. Furthermore, to understand the sexual behaviour of these women and the relatively weak bargaining position of other women regarding sex and non-use of condoms, it is necessary to go backwards in the causal chain and look at the political economic history of the country and the role of women therein. In the core tradition of Human Geography we present spatial processes and local economic context with a historical perspective that according to our view constitute the most important explanations. The evolution of the country's economy and the importance of labour migration are necessary to know in order to understand the epidemic. This also helps to better grasp the underlying reasons for young girls' sexual activities and thus teenage pregnancies today. The main point in the article is well captured by the concept of female economic insecurity. Only to mention the two most important dimensions, women's productive role, and thus command over resources, and their traditional lack of inheritance rights, determine to a large extent their degree of economic security. In this transactional perspective we establish four risk groups of women based on our empirical observations.

The objective of the article is to substantiate the above arguments. The data are based on Hesselberg's rural and urban fieldwork experiences in Botswana in the period 1976-88 (Hesselberg 1985, 1989) and fieldwork by Iversen in Francistown in 1994/95/96 (Iversen 2000, 2005). The experiences and information presented are from the period *just before the start of the epidemic and when it really took off* in the country.

Method

The empirical information used in this article stem from several different types of sources. Hesselberg conducted surveys in the villages Lethlakeng and Tutume on agriculture, labour migration and levels of living in 1976 and 1978 spending half a year in the villages each time. He made a study on changes in the settlement pattern in the regions of the two villages in 1980 (Hesselberg 1982); a pre-study in Francistown on urban-rural linkages in 1988 (Hesselberg 1993a); and he has made several visits to Botswana during the 1980s and early 1990s to supervise M.Phil. students in their thesis work. The arguments in the article are based on his observations, interviews with a large number of rural and some urban respondents in their homes; informal talks with especially young women; and extensive reading. Since these surveys and observations were conducted before the HIV/AIDS epidemic became known, this topic was not researched upon by Hesselberg. Although sexual behaviour and networks were not his research objective, his observations and informal talks about these issues with a large number of young people over the years are now together with his study of labour migration relevant for understanding the extremely high level of HIV/AIDS found in Botswana. Iversen studied the epidemic in the low-income parts of Francistown. He started his fieldwork in 1994. Together with a female M.Phil. student (Christine Wiik) he made 540 interviews about gender issues. Out of these respondents 103 women, who had a boyfriend but were not married or cohabiting, were selected for further questions about sexual behaviour and HIV/AIDS. Furthermore, nine of these women again were later interviewed in-depth about their life and sexual history as well as knowledge and views on HIV/AIDS. He returned for a short follow-up study in 1996.

The Epidemic in Botswana

The first AIDS case was reported in Botswana in 1985 (MacDonald 1996)[2]. The *epidemic* became ?visible' only in the mid-1990s (UNDP 2005, p. 20). In 1994 there were 4 400 estimated deaths (the cumulative figure was 12 000 for the period 1987-1994) (AIDS/STD Unit 1994). The estimated figure for AIDS related deaths was 23 000 in 2003 and in 2007 the figure was 16 000 in a population of only 1.8 million people (the population figure applies to 2005; by 2050 the population figure is estimated to be reduced to 1.7 million) (UNAIDS/UNICEF/WHO 2004, 2008; UNFPA 2005). UNAIDS/WHO (2005) maintain that the epidemic in southern Africa continues to intensify, whereas it appears to stabilize in Botswana. The country was probably at the top of its epidemic with *37.3%* of the adult population (15-49 years) infected in 2003 (UNAIDS/WHO 2004; UNICEF 2004a; Thurlow 2007). Today, only Swaziland has a higher percentage than Botswana. UNFPA (2005) places the prevalence in Botswana in the range 32-43%. UNAIDS/WHO (2005) refer to a household survey that concludes with a relatively low prevalence figure of 25%. However, UNAIDS/WHO point out that the method used in obtaining their figures, which are based on calculations from antenatal clinic data, are more robust. The group with the highest HIV prevalence at the beginning of this century was *young females* (15-24 years). Estimates of infection in this group vary between 30-45% (compared to 13-19% for young males). Now the estimate has been reduced to respectively 20.8% (female) and 7.9% (male) (UNAIDS/UNICEF/WHO 2008). In the age group 15-24 females are 3-6 times more at risk than men in southern Africa. There is undoubtedly a feminization of HIV at the present phase of the epidemic in this region. Furthermore, the infected in Botswana, as elsewhere in southern Africa, are becoming younger; more than half of new infections are found among those below 25 years; and three quarters of all young infected people are female

[2] www.avert.org/aidsbotswana.htm 7 September 2005.

(UNAIDS 2005; UNAIDS/UNICEF 2005; UNAIDS/WHO 2005). Even if this holds true, UNAIDS/WHO (2005) report that infection levels among older people in Botswana are unexpectedly high. The figures for the age group 45-49 and early 50s are 29% and 21% respectively.The mining town Selebi-Phikwe has the highest figure for *pregnant women* with HIV - 48% (2003) (UNAIDS/UNICEF/WHO 2004). The figure was 27% in 1993 (AIDS/STD Unit 1994). Pregnant women attending antenatal clinics in *urban* Botswana have a prevalence rate of nearly 40% (UNAIDS/UNFPA/UNIFEM 2004). (The figure for Swaziland is 43% on average, and as high as 56% in the age group 25-29.) The infection level in Botswana for pregnant women are on average around 30% (UNAIDS/WHO 2005), and the figure is 33% for young women in the age group 15-24 living in the capital city (UNICEF 2005). Urban areas evidently have higher prevalence rates than rural areas. Geographically mobile people are at higher risk to be infected by HIV than others. This factor outweighs the fact that rural people use condoms less often (due among other things to availability and cost).*Condom use* has increased considerably in the age group 15-49, especially among those with higher education. In 2002 as much as 70% of the women and 78% of the men in a survey said that they used condoms last time they had sex with a non-marital/non-cohabiting partner. Other sources also report wide-spread use of condoms in so-called high-risk sex, i.e. when having casual sex (UNAIDS/UNICEF/WHO 2004; UNICEF 2005). This indicates that the infection rate will decrease in the future, even if sexual behaviour changes only marginally. This information is, however, indirectly contradicted in a survey that finds that only 25% of the respondents knew that

[3] Swaziland is an extreme case of labour migration. A large proportion of men, and now also women, move on a temporary basis to South Africa to find work.

[4] www.avert.org/aidsbotswana.htm 7 September 2005.

[5] It should be noted that condoms are not 100% effective as a protection against HIV infection.

condom use prevents HIV transmission (UNAIDS/WHO 2005). Moreover, UNICEF (2004a) reports from a study in 12 secondary schools at the end of the 1990s that only 48% of the sexually active young women used condoms. Another factor of importance to understand the high prevalence of HIV in Botswana is venereal diseases that were quite common at the time of our fieldworks. This makes HIV infection easier. Thus, people with venereal diseases are highly overrepresented among those with HIV/AIDS. Condom use prevents most genital infections but where at that time in little use, *whereas the pill was very popular among young adult women.*

The African Sexuality Debate

One approach to HIV/AIDS is derived from an individualistic analysis of the epidemiology. This offers no structural causal explanations. It is rather a method of inquiry, and as such it carries certain ontological and epistemological presumptions derived from empiricism and methodological individualism. This limits its explanatory potential. Through large-scale testing of serostatus combined with surveys, the personal characteristics, which are typical of infected individuals, are mapped. The objective is to identify the causes of infection among these characteristics. A central concept is ?risk groups', such as ?sex workers' and ?truck drivers'. The coining of ?risk groups' can, however, be a way of blaming certain groups for being the cause of the spread of the disease. This may lead to stigmatization. This critique is somewhat unreasonable since it fails to differentiate between the approach as such and the way in which it may be misused. As an epidemiological concept, its meaning is simply groups of individuals with an above average statistical probability of being infected. As an example, Iversen (2005) shows that in his sample of 103 unmarried women in Francistown in 1994/95, 66% of those with secondary school or more used condoms regularly, while only 33% of those with less schooling did so. Of the

latter group as much as 52% never used condoms even when having sex with a non-regular partner. A weakness of this kind of approach is its limited capacity to disclose the social dynamics that explain why certain groups of individuals become more highly infected than others.

The ?African sexuality' idea is, by contrast, a highly generalized hypothesis. The main proposition of Caldwell *et al.* (1989, 1999) is that it is possible to [6]distinguish between three types of civilizations – traditional African society; traditional ?Eurasian' society; and modern society – each logically encompassing a set of common attitudes and practices concerning sexuality. It would seem that in Caldwell *et al.*'s opinion no part of the world can yet claim to be fully modern in this sense, contemporary Western society is in a transitional phase between being traditional Eurasian and fully modern. The main emphasis is, however, the comparison between the Eurasian and the African system. Caldwell *et al.* explicitly built their concepts on Goody's (1976) work. Goody's main point is that differences in natural conditions lead to different types of agricultural technology and levels of productivity, which in turn lead to the emergence in Eurasia of a class system based on private ownership of land. African societies, on the other hand, continue to be relatively egalitarian. For wealthy families in the class-diversified Eurasian societies it became important to control the sexual conduct of their daughters so that the family assets should not be watered out by intermarriage with less wealthy families. Female chastity was consequently made to be a central moral and religious norm. In Africa, by contrast, the main focus was on fertility because large families, rather than land, were the way to prosperity. Thus, it was not necessary to make sexual conduct a prime moral concern.

[6] Muslim parts of Africa must be included in the Eurasian type society. The strict control of female sexuality by religion in muslim societies is for instance well described by Ali's (2005) experiences from Somalia. She uses the concept shame culture to depict how girls' sexuality is linked to the honour of their fathers, families and communities. Thus, premarital (and extramarital) sexual activities are heavily punished.

Caldwell *et al.* made clear that the Eurasian view of female sexuality was repressive in its ?obsession' with female chastity. The formulation of the ?African sexuality' concept thus encompassed a moral attack on the Eurasian system. As the main victims of this system were seen to be women, there was also an implicit feminist perspective in Caldwell *et al.*'s writings. Although they maintain that the African system is superior to the Eurasian regarding women's freedom, the disadvantage is that having multiple or parallel sexual partners lead to a higher incidence of sexually transmitted diseases. Moreover, this implies that Africa is more vulnerable to the spread of HIV than areas belonging to the Eurasian system.

Caldwell *et al.*'s ideas led to a debate over the underlying moral attitude among those using the ?African sexuality' concept. The use of the term was, for instance, seen as an inherent moral attack on Africans, in particular on African women (Arnfred 2004a). Thus, it is maintained that African women are implicitly blamed for the spread of HIV. Caldwell *et al.* are aware of this danger, and explicitly remark that using a term such as promiscuous to characterize African sexuality, would be seeing it from a traditional Western point of view. Instead, they use the term permissive. However, that is again a value-laden term. It is difficult to escape an ethnocentric language. In our view, it is possible to read Caldwell *et al.*, and to use their insights, without taking into account their *possible* Christian moral value of female sexuality (and of course, to blame women for the HIV/AIDS epidemic, makes little sense). Still, we think Caldwell *et al.* overstate their case. To give just one example: Based on their anthropological sources, they equate the normality of sexual relations in pre-colonial sub-Saharan Africa with drinking and eating. This view has been criticized since African sexuality traditionally had many restrictions and it was shameful for a girl to become pregnant before marriage (Heald 1995; Delius and Glaser 2002). Even Caldwell *et al.* (1992) admit that ?severe punishments were often imposed on females and their male

partners, for pre-marital and extra-marital sexual relations' (p. 388). Hunter (2004) found that pre-colonial Zulu custom allowed certain but *limited* sexual activities for pleasure before marriage provided that the girls did not get pregnant. According to Hunter (2005), ?sexual practices that avoided childbirth were relatively freely permitted' (p. 143). Furthermore, a young man was expected to marry his girlfriend if she got pregnant (Hunter 2002). Among the Tswana, youth learned about sexual behaviour during initiation ceremonies but premarital sex was condemned and punished (Schapera 1933; Meekers and Ahmed 2000). Thus, in Botswana marriage was the norm, and men's and the families' role and responsibilities in economic support of women unquestionable. To be an unwed mother was an exception because there was traditionally a strong social norm against becoming pregnant before marriage was arranged by the parents. To us, it seems that much of the confusion and contradicting statements in the African sexuality debate are ?due to an absence of a definition of ?sexual relations'. In traditional African sexual behaviour Caldwell *et al.* probably do not include penetrative sex which may lead to pregnancies. Those criticising Caldwell *et al.* have clearly read their articles to mean exactly that.

The norms covering sexuality were changed during colonial times. Schapera (1933) found that premarital pregnancies had at the end of the 1920s become quite widespread among the baKgatla. Furthermore, girls growing up in Botswana in the 1950s and 1960s were influenced by the sexual values and norms stemming from traditional ideas *and* from Christian missions and colonial schools. The former, although having many restrictions on sexual activities, was not as controlling as the teaching of female chastity of the latter. However, missions in the early colonial period also contributed to a

---

[7] Caldwell et al. do not define what they mean by ?traditional Africa'. Does it denote pre-colonial times only or does the concept also include the early colonial period?

more permissive sexual behaviour by their efforts to terminate traditional punishment methods for girls becoming pregnant before marriage. Finally, in the 1970s young relatively educated women were probably to some degree influenced by the fashion of young ?flower power' people in America and the notion of ?free sex', which was blown out of proportion by eager media. Of course men were at the time influenced by the same three sources. Since restrictions on male sexual freedom were less traditionally and more weakly expressed in Christian teachings, men typically ?took advantage of the sexual opportunities available to them', as one of our male Batswana assistants put it.

Ahlberg (1994) can be said to represent another critical voice of Caldwell *et al.*'s work. She addresses several important issues: Is it possible to generalize at such a level as Caldwell *et al.* do without falling into an essentialist trap? The diversity among traditional sexuality in Africa is so great, as to make it analytically meaningless to talk about one ?African sexuality' (Helle-Valle 2004). Is it possible to grasp an understanding of sexualities in Africa based primarily on an analysis of pre-colonial conditions? In our opinion a theory of sexualities in Africa should take into account the effect of colonial domination. The problem with the work of Caldwell *et al.* is that it remains focused on an understanding of pre-colonial society (although much of the research, on which they base their study, is from the colonial era). Mbali (2004) makes the point that it may be Western colonialist discourses that created the impression of permissive African sexualities due to a need for ?othering' Africans in order for Christian sexual moral to become clearly different.

In the 1970s sex with several partners among young adults, premarital or extramarital, was regarded as acceptable by this group, and it was not meeting strong negative reactions from the rest of society when the relationships were not too visible in practice. The same attitude existed in

1995 when Meekers and Ahmed (2000) made a survey in urban Botswana finding that multiple partners were common among the youth. The present article looks at colonial and post-colonial reasons for this sexual attitude and behaviour of both men and women. More importantly, the focus is on women's economic and social situation making it difficult, sometimes impossible, for them to refuse unwanted sex. Furthermore, the article argues that there is a third way of looking at female sexuality between desire based on love and outright unwanted sex. Women's goal may well be a combination of sex for joy and economic gain.

The political economy approach directs the main explanatory focus on relations of power along the axis of gender and of socio-economic groups. The vulnerable position of poor women is thus seen as a decisive factor shaping the epidemic. Poverty and unequal gender relations leave women in a position were condom use is hard to negotiate (Preston-Whyte *et al.* 2000; Barnett and Whiteside 2002; Booth 2004; Stillwaggon 2006). Moreover, multiple partners are often necessary to secure a sufficient income. Poverty also leads to widespread migration which in turn makes multiple partners common (United Nations 2005). This approach explicitly rejects any form of cultural determinism. Rather, the cultural norms and practices, that regulated sexuality in pre-colonial societies, are seen as being changed by the impact of colonialism. Furthermore, although this approach is promising, it carries with it certain dangers. There is a tendency to make broad generalizations based on the category 'poor women'. The specificity and complexity of lived experiences are thus lost. An understanding of complex life situations can be reached if the dynamics of women's socio-economic status and roles, and how they are shaped by the political economy history, are analyzed. There is therefore an urgent need for contextualizing research that shows how societal change creates different realities for different groups. Although these groups may have aspects like poverty and gender in common, they may be in different risk situations. This article demonstrates how broader processes of

political economy result in different probabilities for different women to become infected by HIV. In arguing for a political economy approach, we do not imply that culture is unimportant. For instance, if pre-colonial sexual norms had been strongly favouring female chastity, the later labour migration economy would probably not have had the impact it had on the diffusion of HIV/AIDS. It is beyond the scope of this article to discuss the evolution of the pre-colonial sexual norms.

The Basic Causes of the Epidemic

It has been established that labour migrants in Africa have higher infection rates than other groups independent of the HIV prevalence in both the home and work area (Poku 2005). *Male labour migration* leads among other things to spatially *split* households/partners and to that single men are away from their local community for relatively long periods of time. A large share of the men in Botswana used to be on 9 or 12 months contracts in the gold mines in South Africa from the 1890s to the 1970s (Kerven 1979). More recently labour migration to urban Botswana is more important as a destination for a transition period before whole families move away from the rural areas. In fact, many men and recently some women sought and seek work in *several* urban places in Botswana and South Africa, thus making a family split among different locations. This *multilocal* nature of many families and partners and the rural-urban circulation of especially a large part of the country's young men are reasons for a rather wide-spread sexual activity network, which is particularly conducive to the spread of HIV. In our opinion the point is valid that before Bechuanaland became a protectorate under the British in 1885, sexual activities were controlled by society to some degree and having parallel partners were clearly less common than in later periods. Female sexuality was not at all ?free', although it may have been more ?permissive' than the Eurasian strict chastity described by Caldwell *et al.* (1989).

Why did labour migration become such a dominant characteristic of Botswana's economy and society? As a landlocked and sparsely populated semiarid area with recurrent and serious droughts, the economy the British met in the 19th Century consisted of groups living on mixed farming with cattle rearing as the main activity and crops as the minor (Schapera 1971; Silitshena and McLeod 1984; Tlou and Campbell 1984; Schapera and Comaroff 1991). Millet and sorghum were the staple foods before maize became more popular after independence in 1966. The area did not have known resources sought after by the British but ivory and ostrich feathers. The number of elephants and ostriches diminished fast, leaving the country without any valuable export commodity. Thus, the British intent in the area was mainly to keep other European nations out, especially the Germans who wanted to establish a corridor from Namibia to the Indian Ocean cutting off the British colonial aspiration of a south-north continuous territory. Today's Botswana was accordingly only a protectorate with few British imposed changes. However, missions started a few schools and a common administration of the territory was established. Importantly, no physical infrastructure was provided but for the railway from Cape Town to Harare passing through Bechuanaland. At independence only 7 kilometres of tarred road existed in the country (UNDP 2005). The lack of economic interests by the British Government and private business can best be symbolised by the fact that the administration of Bechuanaland was located in Mafeking, a town outside the territory. Gaborone first became a small settlement and capital after independence.

The effects of the British administration had, however, many similar aspects as in proper colonies, such as a gradual change of traditional laws. The main factor is the imposition of taxes *in money*. At first every family had to pay a so-called Hut tax, later individuals were issued Poll tax, again to be paid in money. This introduction of taxation to finance the colonial administration

forced families living in a non-monetised economy to send young men to the newly discovered gold deposits in South Africa from the 1880s onwards. There was a coincidence in time between the need for money among the Tswana and the rapidly increasing demand for labour in the British owned mines. Many mines in South Africa have a low gold content in the rock, thus high prices on gold and low cost on labour are necessary conditions for the mines to be operated. The mining companies went on recruitment drives to Bechuanaland (and to Swaziland, Lesotho and Malawi). The local chiefs encouraged the young men from the start of gold mining to go to South Africa because the chiefs got 10% of the tax collected in this so-called indirect rule of the British. The men worked hard in the mines, and many became ill. They lived in hostels at the mines. They often used their meagre wages on beer and women, and penetrative sex was the norm. Young labour migrant men came back to the home village during peak crop cultivation work for preparing the fields. The need for both earning some money in the mines in South Africa or later in urban Botswana *as well as* producing food for own consumption and barter in the local area explains the unusually high *geographical mobility* in Botswana (and in the rest of southern Africa). Thus, *the pattern of sexual behaviour found today can be said to have its origin in the early labour migration economy of the Bechuanaland period*. Interestingly, a similar argument was made by the medical doctor Kark regarding the effect of labour migration on the diffusion of syphilis in South Africa in the 1930s and 1940s (Marks 2002). Of course, labour migration as an important factor for understanding the HIV/AIDS epidemic is not unique to Botswana. Schoepf (2008) for instance makes a similar argument for Zaire. The point is that labour migration was more widespread and comprised a larger part of the young men in Botswana than other countries in sub-Saharan Africa (except Swaziland). Another interesting example of the consequences of labour migration is Belle Glade, a small agricultural area in south Florida, USA, which by 1985 had much higher HIV prevalence than the average of the

country. Media gave the explanation as race and class in a bounded space. However, later research showed the reasons to be seasonal migrant labour from Caribbean countries coming to harvest sugar cane, and their participation in local sexual networks. Similar to Botswana, women in Belle Glade stated that they had boyfriends who provide them with goods and practical help (Raimondo 2005). The diffusion of HIV from the Caribbean to USA showed the spatiality of AIDS. Raimondo rightly points out that: ?An understanding of the geography of its [the transnational sugar industry's] political economy might have offered a very different perspective on the meaning and risks of migration' (p. 55); and that ?the geographies of migration and resultant health challenges' (p. 62) would have given a different story.

To a more limited extent, the HIV/AIDS epidemic has roots in the *cattle economy* where men were away from the village for longer periods living at cattle posts or taking their herds even further away to places of available grazing. This separation of men and women may have motivated some of them to have more than one sexual partner, and thus influenced the general sexual norms. Undoubtedly, a consequence of the cattle economy was that women got a fairly independent role by being in charge of family affairs, and of crop cultivation after the men had done the field clearing and ploughing with oxen (Bond 1974; Driel 1994). The cattle economy together with male labour migration gave women relatively large economic and social activity spaces. This fact has been reported from other areas in southern Africa, for example by Young (1977) who writes: ?Women became virtually rulers of the home and much more economically independent' (p. 78). This degree of female independence should, however, not be overestimated because their economic security depended totally on the men (husbands or fathers). At the time young single women seldom travelled to town, they lived in farming

households that had very little money income. Cattle were a form of insurance and wealth accumulating activity.[8] Selling cattle was done only when money was really needed for special purposes or occasions. Importantly, women had to get access to land for crops either from a father or a husband, they could not own cattle, and there were no other economic activities they could engage in but local beer brewing. Beer brewing and party arrangements were a livelihood strategy as well as a way for young women to become less dependent on handouts from their fathers. However, to obtain economic security, it was imperative for women to marry. Labour migration led to a surplus of women in rural areas, and thus a difficulty for quite a number of them to find a husband. The pressure was on the young women to compete for a suitable man. Already in the 1920s Schapera (1933) found that this resulted in more 'permissive' sexual behaviour as well as more tolerance towards premarital pregnancies: 'The modern Kxatla girl, with her short European skirts and irresponsible behaviour, often herself takes the initiative in love-making' (p. 87); and 'although the general tribal attitude towards premarital pregnancy has grown so much more tolerant, such an occurrence is not yet altogether condoned' (p. 85).

After independence the money economy gradually increased and barter options declined. More and more of necessities and 'luxury' goods had to be bought in shops. One of the authors remembers vividly young girls in the 1970s going through catalogues of dresses from South Africa. The only hope for getting a dress was gifts from men who were home from labour migration or to ask their farming fathers for money. As prices on average increase more

---

[8] Ownership of cattle today is very skewed. According to UNDP (2005): 'Among traditional farming households, 47% have no cattle and 24% have between one and eleven. At the other extreme, the wealthiest 2.5% of farming households own 40% of the national herd' (p. 17). Furthermore, 66% of female farmers have no cattle at all.

rapidly on manufactured goods than on food, farmers either have to produce more from putting in more labour or apply ?costly' inputs to obtain better productivity. This price-squeeze in which peasants and farmers find themselves, results in money problems. Small farms easily become economic unviable. The alternative, which is found all over the world, is for farmers or farm families to become *multiactive*, meaning they must engage in economic activities outside their farm. This can be farm work on big farms, handicrafts and wood gathering, jobs locally or away from the home village. Multiactivity and multilocality were widespread among rural families in Botswana already by the 1970s (Hesselberg 1985) and are more so today (Geiselhart and Krüger 2007). Thus, the local context was in this respect conducive to the spread of HIV/AIDS. Even poor urban households often have several livelihood strategies, trying to eke out an improved life from several sources in different locations. These households may thus be spread over space, in urban and rural areas, in small towns and big cities, and in Botswana and abroad. The end result is that it is quite common that even nuclear families are split with husband and wife being in different places, while small children may remain with their grandparents in a village.

In the 1970s Botswana started to export *diamonds*. The obtained foreign exchange gave the country an option to invest in physical and social infrastructure. Furthermore, the violence associated with the apartheid regime in South Africa spilled over into Botswana making it a prime receiver of funds and attention from Western governments and NGOs. The *assistance* and influence from outside were important for development especially of the school and health systems. Thus, Botswana got a spatially dispersed and well functioning clinic system. Foreign donors were instrumental in achieving this success. The registration of HIV/AIDS cases can therefore be said to be quite good. The country's small population also helps in explaining why

probably close to all infected people are accounted for today.[9] The foreign influence also affected the diamond industry giving the government a gradually larger share of the revenues through various taxes. Botswana has a mineral economy and the mines constitute about 40% of GDP, 80% of export value, and 50% of government revenues (UNDP 2005). About 60% of the profit from mining accrues to the government. However, diamond mines employ few people (less than 5% of the formally employed), and to diversify the economy has proved very difficult (Colclough and McCarthy 1980; Salkin *et al.* 1997; Taylor 2004; Leith 2005). As a result, unemployment and poverty[10] were and are serious problems in the country (Taylor 1986; Hope and Edge 1996; Hillbom 2008). Thus, women have received education but few jobs are available to them outside the government sector.

Similarly, the government now has ample funds, and it has adopted a range of successful ways to give relief to the population when drought hits over several years (Geiselhart, Gwebu and Krüger 2008). Krüger and Grotzke (2008) report from a qualitative study in Lethlakeng that due to recurrent droughts, households more and more rely on government support. The situation may now be that traditional coping mechanisms to drought are not easy for rural people to engage in. Hesselberg (1993b) makes a similar argument by pointing out that the poor may be better off in periods of drought due to employment on public works paid in money. Thus, Botswana had relatively good physical and social infrastructure already by the early 1980s, but the government then and now finds it difficult to translate diamond wealth into sufficient employment.

---

[9] A well developed health system contributes to the explanation of a high rate of infection, as does the opposite. Populous countries with many unregistered HIV-cases may have a low offical statistical rate.

[10] The figure of income poverty in Botswana, according to the low absolute World Bank definition of 1.08 (1993) dollar per person a day, is 31% (UNICEF 2005).

Four Risk Groups of Women

Our experiences tell that some characteristics of women make them more vulnerable to HIV infection. For the sake of simplicity we establish the following four risk groups: 1) Young educated women with a job who thus have relatively high economic security; 2) married women in rural areas with a labour migrant husband who have medium economic security; 3) women without high education and without a permanent job who are economic insecure; and 4) girls going to secondary school or studying at higher levels staying away from home who are both economic and social insecure.

The *first risk group of women* of relevance to the HIV/AIDS epidemic in Botswana comprises educated women finding work as nurses and teachers and jobs in police and government departments. A common aspect of these jobs was that the government decided where a person should work. This often led to split families and partners. Our experience from talking to many young women over the years is that sex with other men than the husband/boyfriend was seen to be an accepted norm. However, they were very selective of the kind of person to have sex with. In a society with *high geographical mobility, split households and the placement of partners in different parts of the country make it difficult to have stable sexual relationships*. Women took after the male practice of casual sex. Hesselberg's experience with assistants, who interpreted during interviews in remote areas, is telling. The assistants were of both sexes, they were educated and in their twenties and lived in urban Botswana. When he was on rural fieldwork, the female assistants were equally engaged in sex, as the male. It did not matter whether they were married or not or had children or not. It was clear that having several sexual partners was accepted by this age group at the time. Furthermore, it was common for the assistants and many of the women we interviewed and spoke to, to have children with different fathers. When the epidemic became well known, this risk group of women probably demanded condom use. However, according to our information, few did so in the early phase of the epidemic

mainly because little was known about HIV/AIDS and the link between the disease and sexual behaviour. Furthermore, the pill was available to protect against unwanted pregnancies. In the *present* phase of the epidemic *other and poorer groups of women* have become the main risk groups. This point is supported by the fact that the growth of the economy and increase in employment, not least in government administration, and a resulting urbanisation during the last two decades, have made a number of educated women more economic independent. In addition, it has become much easier for women, who moved to towns, to get a plot of land in their own name resulting in more economic security.

A Botswana Government programme for urban self-help housing in the 1980s, which included a plot of land and subsidies for building, was very important for women's independence. Thereby land became available for them from the government and not as before only through the patrilineal group. This meant that women did no longer have to rely on men for access to *urban* land. Many women applied for a plot and started to build a shelter. If she then got married, the husband could later divorce her and take the house although he had not contributed to it. This is a reason for women to prefer to have informal sexual relationships rather than to marry. The usual way women formulated this to us, was: 'We don't want a man that by custom can demand hot water to wash in the morning and that may hit us without it being a crime.' This situation has been reported also from other African countries – women say that in their culture men have a right to beat their wives if they argue with them or otherwise do not carry out their wifely duties satisfactorily (Epstein *et al.* 2004; New York Times/Dagsavisen, 20 August 2005). Thus, some African men look upon a wife as a kind of property paid for by the bride price. Thus, the number of female-headed households (both *de jure* and *de facto*) is understandably high in Botswana (Kossoudju and Mueller 1983). The *de jure* figure is 47% of all households (UNDP 2005).

The *second risk group of women* consists of those still living in villages with men working elsewhere. Many of them have now stopped cultivating crops (Hesselberg and Wikan 1982, Wikan 2004). This is due to the low income from crops; the uncertainty of rainfall making the risk of little output high; and quite substantially increased real wages in urban jobs giving sufficient remittances. This group's sexual behaviour is mixed, and having several partners is not, in our experience, a dominant pattern. It is, however, difficult for a married woman in a rural area to demand condom use from her labour migrant husband. Raising the issue of condom use in a stable relationship shows lack of trust and 'is frequently interpreted as an insult' (Jungar and Oinas 2005, p. 13). Married women therefore rather risk HIV infection than ask their husband to use a condom. Many men also find it difficult to admit their HIV-positive status to their wives. (Of course when a couple wants to have children, the question condom use is irrelevant.) Thus, the wife's fate depends on what the husband does when away. The duration of staying away for work varies today, but it can still be for several months. Two important factors regarding time spent away from the home village are distance to the place of work and whether or not the husband owns cattle.

The *third risk group of women* consists of those with less education and/or without a permanent job. Many of these women moved to urban areas during the 1980s. The best way for rural women to get away from patriarchy is geographical and social mobility. Towns are in addition attractive due to more opportunities generally. At the beginning of the spread of HIV in Botswana the degree of urbanisation was low, and the extensive urban housing programme had just started. The job opportunities in towns were relatively few, and the possibility to find a place to stay limited. Thus, women had to depend on men when testing out the emerging urban life options. Practical help and money from men were important. Thus, the pressure for sexual favours was high. Iversen (2000) found in the study in Francistown in

1994/95 that as much as 76% (sample size 103) of the unmarried women interviewed, received money regularly from their boyfriends. Furthermore, the reason for having *multiple partners* was that women seldom got enough money from only one man; unskilled men earn little. More than one man was needed to ?survive' at the *chosen* level of consumption. Having children with the men secured more gifts. This is not casual sex with money taken after each sexual act. It is neither prostitution nor sex work in the common understanding of these terms nor a stable boyfriend relationship. Schoepf (2008) writes regarding Kinshasa that not ?all women with multiple sex partners consider themselves prostitutes. ... Although they expect to receive gratuities, these women rejected the idea of using condoms, which were stigmatized by their association with SDT and prostitution' (p. 459). Timberg (2007) reports from Francistown that house rent, clothes and now cell phones are part of sexual exchange. Women in this third risk group, who only had one partner, tended to have a high turnover in their so-called *sequential* relationships. However, in order to obtain sufficient money and reduce income uncertainty *parallel partners* was a solution (Helle-Valle and Talle 2000; Hunter 2002; Arnfred 2004b; Haram 2004; Groes-Green 2005). This phenomenon is also reported from other African countries (Silberschmidt 2004a). Hunter (2002) states regarding South Africa: ?the decline in marriages, and women's increased dependence on men, are arguably critical factors that now make it much more acceptable for men to ?maintain' a handful of girlfriends, even father their children, with little intention of marrying them' (p. 107); and ?women *qoma* (choose a man) ?one for rent, one for food, one for clothes'... and women might also be expected to remit money to rural homes, perhaps to contribute to the upkeep of their children' (p. 111). In southern Africa there is a tradition for men to give women gifts, money and practical help when they have premarital and extramarital sexual

relationships. Importantly, this custom includes the view that in return men can demand condomless sex (or flesh-to-flesh sex as it is called).
Many women, who succeed in finishing an urban house, rent out rooms. Thus, they get a small but steady income. Since men commonly ask for sexual favours, these women have few options but to comply during the house-building period (before becoming relatively economic independent). To demand the use of condom was and is difficult for women under these circumstances. This was especially the case in the early phase of the epidemic. Furthermore, a father, who is not currently together with the mother, must pay for the child's expenses. To get pregnant, women told us, was also a way of getting a small and steady money income for some years. As a result, it is not uncommon to have children with several men. In this way the probability that at least one or two men actually pay, increases.
The *fourth risk group of women* is young girls studying and living away from home. They often live with relatives in large villages or small towns where the schools are located. Sometimes they live without grown-ups, several girls and boys in one house. These girls have very little money and they are under pressure to engage in sex. Their bargaining position is low due to the dominant male culture (UNICEF 2004b). Moreover, this culture is strengthened by observations the boys have made at home of the sexual activities of young grown-ups. Most people in rural as well as urban Botswana live congested. In rural areas there are seldom more than one or a few rooms in the house. Thus, sexual activities are difficult to hide. The teenagers are influenced by the prevailing culture, and the consequence is especially hard on the girls because when pregnant they are expelled from school until their child is one year old (Kann *et al.* 1988). Few return to school because they are not allowed to attend the same school but must find a different school in another community, village or town. Meekers and Ahmed (1999) found in 1988 that pregnancy caused 8% drop-out of girls from primary school and 20% from secondary school. In 1996 18% of the girls in

the age group15-19 became pregnant (UNDP 2005). The use of condoms may also be less common since it is difficult for boys in that age to get access to them (Meekers *et al.* 2001). Moreover, ?sugar daddies' is also a phenomenon in Botswana: ?In southern Africa, many older men seek out young women and adolescent girls for sexual favours while providing them with school fees, food and highly sought after consumer goods' (UNAIDS/UNFPA/UNIFEM 2004, p. 8). Delius and Walker (2002) report from South Africa that ?girls are indifferent to their [men's] advances if they cannot provide the three Cs – cash, cars and cell phones' (p. 7).

Conclusion and Perspective

Our experiences from the context at the time of our fieldworks make it useful to divide women into four risk groups. *First*, among educated young women with a job we found casual sex to be quite accepted and thus partner turnover was relatively high. In the beginning of the HIV/AIDS epidemic the illness was not generally known. These women did then not have to demand the use of condoms because the pill was available and popular. Later in the epidemic more and more of this group probably changed their behaviour. At the present peak of the epidemic, when nearly everyone in Botswana has an experience of a close relative or friend dying of AIDS, partner turnover is probably reduced among women of this group. We have no information about this. However, the same view is held by, for instance, Schoepf (2008) who states: ?Those who have reduced their risk are women with decision-making autonomy based on their capacity to support themselves without resorting to sex within or outside of marriage' (p. 461). *Second*, among rural married women dependent on a labour migrant husband our experience support a low participation in sexual networks. Their problem rests on the sexual behaviour of the husband since to demand the use of condoms was and is difficult for

them. *Third*, among less educated women with casual jobs our information is that so-called *coping sex* was rather widespread. The women obtained money, goods and/or practical assistance from sex but they were not sex workers. Poverty forced and forces many women into ?subsistence sex' or transactional relationships that made and makes condom use difficult. Our experience is that the reason for the relationships was not necessarily survival but to obtain a higher material consumption, a better life. Among this third risk group many used to have parallel partners. They had a boyfriend staying elsewhere, in addition to a local partner. The women depended on the men, either all the time or in periods when they had little food, lost their income source or got ill. If the men demanded condomless sex, there was little women could do but comply. Women often lack negotiating power (?bedroom power') social norms make it difficult to insist on condom use. In this economic rational view of transactional sex it is easy to lose sight of romantic love. Having several partners can, of course, also be based on love. Unfortunately, it is being said that it is difficult for a woman in love relationships to demand condom use. *Fourth*, youth going to school away from their families are easier for boys to pressure into unwanted and condomless sex. Generally, girls wanting to keep their boyfriends often do not have a choice but to follow the want of the boy. However, this is not to say that one should expect young people to abstain from wanted sex.

The reasons for the above different situations of women in Botswana and the high prevalence of HIV/AIDS, when going backwards in the causal chain, can be found in the country's history of labour migration and cattle grazing system. Most men were engaged in these activities which led to *split households/partners and multilocality*. The need to secure an income from several sources led to *multiactivity and high geographical mobility* of the people. Moreover, most women were and many still are *highly economic*

dependent on men. In such a situation it is no wonder that casual sex, high partner turnover and parallel partners evolve and that condomless sex was and is common when preferred by men.

It is necessary to state the obvious that there are also many people in Botswana who adhere to cultural values where the family is important and having several partners is out of the question. The typical is, however, that in the period 1975 to 1995 the cultural pressure was low on premarital as well as extramarital sex. Moreover, a large part of the women in Botswana did not get married, thus giving a high share of female-headed households. Furthermore, the limited opportunity for independent livelihoods gave women few choices to male sexual pressures although the women were heading their own households. In the early phase of the epidemic also young educated women with a permanent job were at risk of infection due to a relatively permissive sex culture and the popularity of the pill. However, the major explanation then as well as later were low-income and economic insecurity. Thus, the way forward is to find ways to improve relatively poor women's economic independence and security. By reducing their economic vulnerability to risks such as lack of rain, loss of job, problems with other income sources, or illness, their sexual bargaining position will be greatly enhanced. Then they can choose to abstain or demand the use of condoms.

It is probable that unsafe sexual behaviour has declined with less partner turnover and more condom use today, although some officials involved in the prevention programmes maintain that little change has occurred in sexual behaviour among the young in spite of heavy media messages of the dangers involved. [11]The hypothesis for further studies in Botswana should, in our opinion, be that the male demand for condomless sex has changed somewhat due to the high level of knowledge of HIV/AIDS. However, alcohol use and the macho-culture may still make a group of young men resist condom use.

---

[11] Avert.org/aidsbotswana.htm 11 March 2009.

The last point is well expressed for South Africa by Hunter (2004): ?Men celebrating multiple sexual partners ... are in their present form, a product of an economic crisis that has ripped the core out of previous expressions of manhood' (p. 145); or in the words of Walker (2005) regarding young men in the township Alexandra: ?uncertainty around the nature of masculinity and male sexuality, and the expectations men have of themselves, each other and women are contested and in crisis, giving rise to new notions of manhood' (p. 180). This view is also supported by another study of young men in South Africa: ?In many cases, risky sexual behaviours were equated with being ?manly' (Reddy and Dunne 2008, p. 166). Silberschmidt (2001) makes a similar observation in Kenya, and she states: ?an understanding of the risky conduct of men cannot be achieved without analysing masculinity and paying attention to the socio-economic conditions under which it is constructed' (2004b, p. 53). In an article in a Danish newspaper Silberschmidt points to the unfortunate fact that most strategies against AIDS focus on women (Weekendavisen 2-8 December, 2005). Scorgie (2002) points out that: ?Where responsibility for sexual abstinence is placed so unambiguously on the shoulders of young girls, the implication that they are therefore also responsible for the spread of the disease is only a short step away' (p. 67). Instead, men and their behaviour should be the focus of analyses and interventions. We have come to agree with this increasing focus on men in HIV/AIDS research and prevention. However, the basic cause of the epidemic is, in our opinion, women's economic vulnerability, and thus research should, in addition to a cultural perspective (especially certain men's unwillingness to use condoms), include political economic viewpoints. The latter is not sufficiently treated in the African sexuality debate.

References

AIDS/STD Unit. (1994) Current and future dimensions of the HIV/AIDS epidemic in Botswana. Ministry of Health, Gaborone.

Ahlberg, B.M. (1994). Is there a distinct African sexuality? A critical response to Caldwell. Africa 64: 220-242.

Ali, A.H. (2005) Jeg anklager. Jyllands-Postens Forlag, København.

Arnfred, S. (2004a) African sexuality'/sexuality in Africa: Tales and silences. Arnfred, S. (ed.). Re-thinking sexualities in Africa. Nordic Africa Institute, Uppsala.

Arnfred, S. (2004b) Re-thinking sexualities in Africa: Introduction. Arnfred, S. (ed.). Re-thinking sexualities in Africa. Nordic Africa Institute, Uppsala.

Barnett, T. and Whiteside, A. (2002) AIDS in the twenty-first century. Disease and globalization. Palgrave, Basingstoke.

Bond, C.A. (1974) Women's involvement in agriculture in Botswana. Ministry of Agriculture, Gaborone.

Booth, K.M. (2004) Local women, global science. Figthing AIDS in Kenya. Indiana University Press, Bloomington.

Caldwell, J.C., Caldwell, P. and Quiggin, P. (1989). The social context of AIDS in sub-Saharan Africa. Population and Development Review 15: 185-234.

Caldwell, J.C., Caldwell, P. and Orubuloye, I.O. (1992) The family and sexual networking in sub-Saharan Africa: Historical regional differences and present-day implications. Population Studies 46: 385-410.

Caldwell, J.C., Caldwell, P. and Anarfi, J. (eds). (1999) Resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in Third World countries. Australian National University Press, Canberra.

Colclough, C.H. and McCarthy, S.J. .(1980) The political economy of Botswana. Oxford University Press, Oxford.

Delius, P. and Glaser, C. (2002) Sexual socialisation in South Arica: a historical perspective. African Studies 61: 27-54.

Delius, P. and Walker, L. (2002) AIDS in context. African Studies 61: 5-12.

Driel, F.T.M. van. (1994) Poor and powerful. Female-headed housholds and unmarried motherhood in Botswana. Verlag für Entwichlungspolitik Breitenbach, Saarbrücken.

Epstein, D., Morrell, R., Moletsane, R. and Unterhalter, E. (2004) Gender and HIV/AIDS in Africa south of the Sahara: Interventions, activism, identities. Transformation 54: 1-16.

Geiselhart, K. and Krüger, F. (2007) Die HIV/AIDS-krise – Botswanas strategische Antwort als Vorbild? Geographische Rundschau 59: 54-61.

Geiselhart, K., Gwebu, T.D., and Krüger, F. (2008) Children, adolescents and the HIV and AIDS pandemic: Changing inter-generational relationships and intra-family communication patterns in Botswana. Children, Youth and Environments 18: 100-125.

Goody, J.R. (1976) Production and reproduction. A comparative study of the domestic domain. Cambridge University Press, Cambridge.

Groes-Green, C. (2005) Gender strategies in times of change. Changing gender structures, protective practices and women's ?autonomy' in urban Mozambique. Paper presented at the Nordic Africa Days 30 September to 2 October. Nordic Africa Institute, Uppsala.

Haram, L. (2004) Prostitutes or modern women? Negotiating respectability in Northern Tanzania. Arnfred, S. (ed.). Re-thinking sexualities in Africa. Nordic Africa Institute, Uppsala.

Heald, S. (1995) The power of sex: Some reflectios on Caldwells' ?African sexuality' thesis. Africa 65.

Helle-Valle, J. and Talle, A. (2000) Moral, marked og penger: Komparative refleksjoner over kvinner og sex i to afrikanske lokaliteter. Norsk Antropologisk Tidsskrift 11: 182-196.

Helle-Valle, J. (2004) Understanding sexuality in Africa: Diversity and contextualised dividuality. Arnfred, S. (ed.). Re-thinking sexualities in Africa. Nordic Africa Institute, Uppsala.

Hesselberg, J. (1982) Living at the lands or the tap: A dilemma for the peasants in Botswana. Botswana Notes & Records 13: 46-50.

Hesselberg, J. (1985) The Third World in transition. The case of the peasantry in Botswana. Nordic Africa Institute, Uppsala.

Hesselberg, J. (1989) Ten points about Botswana. Hesselberg, J. (ed.). Botswana: Report from a seminar. Centre for International Development Studies, University of Oslo. 15-21.

Hesselberg, J. (1993a) Urban low-income groups' economic strategies and linkages to rural areas: The case of Francistown, Botswana. Dahl, J. et al. (eds). Land, food and basic needs in developing countries. Department of Geography, University of Gothenburg, Series B 83: 160-173.

Hesselberg, J. (1993b) Food security in Botswana. Norwegian Journal of Geography 47: 183-195.

Hesselberg, J. and Wikan, G. (1982) The impact of absenteeism on crop production and standard of living in two villages in Botswana. Botswana Notes & Records 13: 69-73.

Hillbom, E. (2008) Diamonds or development? A structural assessment of Botswana's forty years of success. Journal of Modern African Studies 46: 191-214.

Hope, K.R. and Edge, W.A. (1996) Growth with uneven development: Urban-rural socio-economic disparities in Botswana. Geoforum 27: 53-62.

Hunter, M. (2002) The materiality of everyday sex: thinking beyond ?prostitution. African Studies 61: 100-120.

Hunter, M. (2004) Masculinities and multiple-sexual-partners in KwaZulu-Natal: the making and unmaking of Isoka. Transformation 54: 123-153.

Hunter, M. (2005) Cultural politics and masculinities: Multiple-partners in historical perspective in KwaZulu-Natal. Reid, G. and Walker, L. (eds). Men behaving differently. Double Storey, Cape Town.

Iversen, A. (2000) AIDS i Afrika. Kvinners smitterisiko i Francistown, Botswana. M.Phil.thesis in Human Geography. University of Oslo, Oslo.

Iversen, A. (2005) Transactional aspects of sexual relationships in Francistown, Botswana. Norwegian Journal of Geography 59: 48-54.

Jungar, K. and Oinas, E. (2005) Mobilize and mourn. The Treatment Action Campaign transforming notions of HIV-prevention. Paper presented at the Nordic Africa Days 30 September to 2 October. Nordic Africa Institute, Uppsala.

Kann, U., Mugabe, M. and Phake, K. (1988) Teenage pregnancies in Botswana. How big is the problem and what are the implications. NIR, University of Botswana, Gaborone.

Kerven, C. (1979) Botswana mine labour migration to South Africa. Central Statistics Office, Gaborone.

Kossoudji, S. and Mueller, E. (1983) The economic and demographic status of female-headed households in rural Botswana. Economic Development and Cultural Change 31: 832-859.

Krüger, F. and Grotzke, A. (2008) Transforming livelihoods: Meanings and concepts of drought, coping and risk management in Botswana. Casimir, M.J. (ed.). Culture and the changing environment. Berghahn, Oxford.

Leith, J.C. (2005) Why Botswana prospered. McGill-Queen's University Press, London.

MacDonald, D.S. (1996) Notes on the socio-economic and cultural factors influencing the transmission of HIV in Botswana. Social Science and Medicine 42: 1325-1333.

Marks, S. (2002) An epidemic waiting to happen? The spread of HIV/AIDS in South Africa in social and historical perspective. African Studies 61: 13-26.

Mbali, M. (2004) AIDS discourses and the South African state: government denialism and post-apartheid AIDS policy-making. Transformation 54: 104-122.

Meekers, D. and Ahmed, G. (1999) Pregnancy-related school dropouts in Botswana. Population Studies 53: 195-209.

Meekers, D. and Ahmed, G. (2000) Contemporary patterns of adolescent

sexuality in urban Botswana. Journal of Biosocial Science 32: 467-485.

Meekers, D., Ahmed, G. and Molatlhegi, M.T. (2001) Understanding constraints to adolescent condom procurement: the case of urban Botswana. Aids Care 13: 297-302.

Poku, N.K. (2005) AIDS in Africa. How the poor are dying. Polity Press, Cambridge.

Preston-Whyte, E., Varga, C., Osthuizen, H. and Roberts, R. (2000) Survival Sex and HIV/AIDS in an African City. Parker, R., Aggleton, P. and Barbosa R.M. (eds). Framing the Sexual Subject. The Politics of Gender, Sexuality and Power. University of California Press, Los Angelese.

Raimondo, M. (2005) AIDS capital of the world: Representing race, sex and space in Belle Grade, Florida. Gender, Place and Culture 12: 53-70.

Reddy, S. and Dunne, M. (2008) Heterosexual masculinities in the South African context of HIV/AIDS. Dunne, M. (ed.). Gender, sexuality and development. Education and society in sub-Saharan Africa. Sense Publishers, Rotterdam.

Salkin, J.S., Mpabanga, D., Cowan, D., Selwe, J. and Wright, M. (eds). (1997) Aspects of the Botswana economy. James Currey, Oxford.

Schapera, I. (1933) Premarital pregnancy and native opinion. Africa 6: 59-88.

Schapera, I. (1971) Married life in an African tribe. Penguin, Harmondsworth.

Schapera, I. and Comaroff, J.L. (1991) The Tswana. Kegan Paul, London

Schoepf, B.G. (2008) AIDS, gender, and sexuality during Africa's economic crisis. Chari, S. and Corbridge, S. (eds). The development reader. Routledge, London. First published in 1997.

Scorgie, F. (2002) Virginity testing and the politics of sexual responsibility: Implications for AIDS intervention. African Studies 61: 55-75.

Silberschmidt, M. (2001) Disempowerment of men in rural and urban East Africa: Implications for male identity and sexual behavior. World Development 29: 657-671.

Silberschmidt, M. (2004a) Masculinities, sexuality and socio-economic change in rural and urban East Africa. Arnfred, S. (ed.). Re-thinking sexualities in Africa. Nordic Africa Institute, Uppsala.

Silberschmidt, M. (2004b) Men, male sexuality and HIV/AIDS: reflections from studies in rural and urban East Africa. Transformation 54: 42-58.

Silitshena, R. and McLeod, G. (1984) Botswana: A physical, social and economic geography. Longman Botswana, Gaborone.

Stillwaggon, E. (2006) AIDS and the ecology of poverty. Oxford University Press, New York.

Taylor, I. (2004) The HIV/AIDS Pandemic in Botswana: Implications for the ?African Miracle. Poku, N. and Whiteside, A. (eds). The political economy of aids in Africa. Ashgate, Aldershot.

Tinberg, C. (2007) Speeding HIV's deadly spread. The Washington Post 2 March.

Tlou, T. and Campbell, A. (1984) History of Botswana. Macmillan Botswana, Gaborone.

Thurlow, J. (2007) Is HIV/AIDS undermining Botswana's ?success story'? Implications for development strategy. IFPRI Discussion Paper (697).

UNAIDS. (2005) AIDS in Africa: Three scenarios to 2025. Geneva.

UNAIDS/UNFPA/UNIFEM. (2004) Women and HIV/AIDS: Confronting the crisis. Geneva.

UNAIDS/UNICEF. (2005) A call to action: Children the missing face of AIDS. Geneva.

UNAIDS/UNICEF/WHO. (2004) Botswana. Epidemiological fact sheets. Geneva.

UNAIDS/UNICEF/WHO. (2008) Botswana. Epidemiological fact sheet on HIV and AIDS. 2008 Update. Geneva.

UNAIDS/WHO. (2004) AIDS epidemic update. December 2004. Geneva.

UNAIDS/WHO. (2005) AIDS epidemic update. December 2005. Geneva.

UNDP. (2005) Botswana Human Development Report 2005. Gaborone.

UNFPA. (2005) State of World Population 2005. New York.

UNICEF. (2004a) The State of the World's Children 2005. New York.

UNICEF. (2004b) Girls, HIV/AIDS and education. New York.

UNICEF. (2005) The State of the World's Children 2006. Excluded and invisible. New York.

United Nations. (2005) Population, development and HIV/AIDS with particular emphasis on poverty. Department of Economic and Social Affairs, New York.

Walker, L. (2005) Negotiating the boundaries of masculinity in post-apartheid South Africa. Reid, G. and Walker, L. (eds). Men behaving differently. Double Storey, Cape Town.

Wikan, G. (2004) The level of living in rural Botswana re-studied. Norwegian Journal of Geography 58: 1-10.

Young, S. (1977) Fertility and famine: Women's agricultural history in Southern Mozambique. Palmer, R. and Parsons, N. (eds). The roots of rural poverty in Central and Southern Africa. Heinemann, London.