

# **Cultural dimensions of sexuality: Empowerment challenge for HIV/AIDS prevention in Botswana**

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# **CULTURAL DIMENSIONS OF SEXUALITY: EMPOWERMENT CHALLENGE FOR HIV/AIDS PREVENTION IN BOTSWANA**

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## **Abstract**

*This paper argues that sex has to be analyzed and understood from a sociological perspective because sex in itself has a social function. A phenomenological study that was carried out among five ethnic groups of Botswana revealed the importance of taking into account cultural sexual realities when prevention strategies for HIV/AIDS are considered and implemented. Furthermore the study threw light on the ineffectiveness of the current national HIV/AIDS prevention strategy of 'Abstain, Be faithful, and use a Condom' (ABC), a strategy borrowed from the Christian cultural morality of sex. Therefore, this paper advocates for empowerment processes that take into consideration local ways of knowing and delivery modes such as participatory approaches. An effective and sustainable alternative to the current national 'ABC' strategy is to engage people meaningfully in analyzing their current cultural situation and coming up with working strategies that can make a difference in a country seriously affected by the HIV/AIDS pandemic.*

## **Background**

The issue of cultural contexts and patriarchy as well as their implications for HIV/AIDS has received little attention in Southern Africa even though gender inequality was identified as a central feature of HIV/AIDS in Africa. In Botswana, since the identification of the first cases of HIV in 1985, attention has been given to the epidemic. However, the prevention strategy in place has focused on the distribution of condoms, establishment of testing centers, anti-retroviral therapy and capacity building. Research done on HIV/AIDS has focused on bio-medical factors (i.e. types of virus and sexually transmitted infections), impact assessments of HIV/AIDS (e.g. on education, health, economy) and on behavioral studies (e.g. knowledge, attitudes, behaviors and practices).

Botswana shares borders with Zimbabwe, the Republic of South Africa, Namibia and Zambia. Botswana's main natural resources are range and arable land, rich wildlife habitats supporting large animal populations and a variety of minerals, such as diamonds, copper and nickel. Although most citizens are members of the *Setswana* speaking tribes, there are other ethnic groups. Some of these ethnic groups are semi-nomadic such as the

*Basarwa* groups in remoter. There is also a small number of citizens of Asian and European origins. The last census (2001) showed that Botswana has a population of 1.7 million. Botswana is a patriarchal society in which there is sexual division of labor. Marriage is therefore valued, and those who marry receive special status and privileges.

Botswana has the highest rate of HIV prevalence in the world, with 38.5% of the population aged 15-49 being HIV positive. This is double the rate of less than ten years ago. Botswana's population without AIDS is projected to be 2.1 million by 2010, with AIDS the population will only be 1.5 million (UNDP, 2000a) suggesting that the 2021 population will remain the same as 2001. According to Esilaba, et al; (2003) the epidemic in Botswana as in other sub-Saharan countries is mostly sexually driven through two modes, namely, heterosexual and mother-to-child transmissions.

In spite of international support and national commitment, as evidenced by the National Policy on HIV/AIDS (SMTP II, 1997) not only the infection rate is rapidly increasing from 18.1% in 1992 to 36.2% in 2003 (NACA, 2003) but also understanding gaps still exist. For instance, under the prevention strategy there is lack of culturally relevant materials on behavioral change that targets vulnerable groups. Furthermore, traditional medicine, spirituality and other influential cultural factors have not been addressed. Neither have influential people in society been given the opportunity to play a role in encouraging positive cultural practices. These gaps are testimony that Botswana's fight against HIV/AIDS is going to be a difficult and a long one. Against this background, between July and September 2003 a qualitative research study was conducted in the rural areas of Botswana to address one of the gaps, namely, the cultural dimensions of sexuality and HIV/AIDS.

## **Purpose of the study**

The purpose of this study was to understand the cultural dimensions of sexuality within five ethnic groups in Botswana and their perception of the relationship between HIV/AIDS infection and sexual behavior in their unique cultural context. In-depth conversational discussions focused on four research objectives.

- 1) A description of sexuality within each ethnic group (to include sex education, sex rituals and their rationale, role of the different genders, role of the family or society, etc);
- 2) An analysis of the social function of sex in the culture of ethnic groups;
- 3) A description of cultural health education practices and their historical experiences with incurable diseases
- 4) An examination of the perceived relationship between sexuality and HIV/AIDS infection and prevention.

## Methodology

A phenomenological qualitative research approach was used to collect data from five ethnic groups between July and September 2003. The five ethnic groups, namely Bakalanga, Bangwato, Basarwa, Baherero and Barolong, were selected for their unique cultural sexual practices and a rationale for retention of cultural identity based on a specific mode of production.

The *Bakalanga* ethnic group in the North East district traditionally had to depend on arable production. Historically, the Bakalanga ethnic group originates from Zimbabwe where arable production farmers are associated with hard work and high arable production yields in the region. The *Nkadzana* or ‘younger wife’ sexual practice is in line with the need for the family to provide farm labor.

The *Bangwato* ethnic group is in the central part of the country. Bangwato group, the biggest ethnic group in the country is traditionally associated with a mode of production that is based on livestock. Due to the vast area of land that they had access to, there have also been associated with a settlement pattern of three homes, namely, the cattle post (where they keep cattle), lands area (for subsistence arable production) and village (where services such as health, schools, etc are provided). Their sexual practice of ‘*mantsala*’ or playful sex with a blood or ethnic cousin and ‘*setlogolo ntsha dithogo*’ or young girls sex play with ‘mother’s brothers’ was necessary to regulate and control sexual behavior necessitated by seasonal migration between the village, lands (usually between 10 and 30 kilometer distance from the village) and cattlepost (30 – 200 kilometers from the lands are or village).

The *Basarwa* group also referred to as the “first people” are traditionally hunter and gatherers who are now moving to sedentism as they are used by dominant ethnic groups as herders. Their experience with other ethnic groups is characterized by exploitation and marginalization. However, the retention of their sexual cultural identity *Xakanaxaamaa* or casual sex practice with any person is based on the hunting and gathering mode of production which necessitates round the clock male protection of females in a rather hostile environment.

The *Baherero* ethnic group is originally from Namibia. Although traditionally nomadic livestock farmers, they too have adopted the sedentary lifestyle. Therefore, because of emerging permanent settlements characterized by small populations, retention of cultural identity is crucial if they are to penetrate the circles of power and influence in Botswana. Their *Otusira* sexual practice of replacing the dead and sexual contact with relatives in Namibia and elsewhere in the country addresses their unique situation.

The *Barolong* ethnic group, originally from South Africa, is one of the smallest groups in terms of Botswana’s population. They practice ‘*seantlo*’ or wife/husband inheritance. The Barolong villages are in the southern part of the country along the Botswana/South Africa border. In Botswana they are associated with commercial arable production.

Most of the farm work is done by men and boys because of its high labor intensiveness and recently highly mechanized production farm implements. The need for the family to traditionally produce future commercial farmers meant that good parenting is a cultural identity that is important to this ethnic group.

For each ethnic group, five knowledgeable and articulate females aged between 15 and 90 years were selected using a purposeful sampling technique. This age spread was important because it was believed that since culture is not static, sexual behavior might be experienced differently depending on the age. The in-depth conversational interview technique provided an opportunity for participants to discuss openly their ethnic sexual experiences and HIV/AIDS issues and constraints with regard to power, authority/control and other cultural expectations.

## **Findings of the study**

Although data was collected from five different ethnic groups, the analysis of the rich and thick description of each ethnic groups sexual behavior and experience revealed the following findings with unwavering consistency:

- 1) For all ethnic groups, sex has a social function, including procreation, pleasure, family property, exchange, personal interaction, healing/cleansing, religion/spirituality interrelationships and control/oppression means.
- 2) Sex is culturally regulated, and accepted types of sexual behavior are learnt through socialization.
- 3) Each ethnic group has access to national HIV/AIDS education processes but also felt the message has ignored the cultural aspect of sex and health education that most people identify with.

The next section highlights particular practices from each culture, followed by an analysis of the social functions and their implications for a new approach to HIV/AIDS prevention.

## **Cultural dimensions of sexuality per ethnic group**

### ***Kalanga: Nkazana:***

*Nkazana* is a heterosexual behavior practiced by the Kalanga ethnic group in the northern part of Botswana. *Nkazana* (literally translated as “small house”) is a cultural practice where a new husband is given authority to ask for sexual favors from a younger female sibling of the wife. This young girl is identified and introduced to the husband and the community by the family of the wife during the wedding ceremony. “*Nkadzana exists in*

*our culture. When a girl gets married, her youngest sister will be Nkadzana. She will be sitting at the table eating with her sister's husband during the wedding ceremony,"* said a 15-year-old respondent. When the wife is taken to the in-law's home this young girl also accompanies them so that the husband's family can also get to know her. An elderly woman had this to say, *"the practice of Nkadzana is important in our culture because marriage is for procreation and there is no divorce. So if this woman cannot conceive for whatever health reason Nkadzana's children are officially hers. When she gets older or does not satisfy the husband sexually Nkadzana is already there."* It is important to mention that all elderly women from this culture strongly believed that the health of their son in law was the responsibility of the wife's family. So giving this man Nkadzana ensures that he does not sleep with other women outside the family and end up with sexually transmitted diseases.

Data from interviews with both the youth and older women from this ethnic group revealed that sex and sexuality in their context are social constructs. Both the family and societal norms are in place to socialize, regulate and control the sexual behavior of members. For instance, grandmothers start engaging in sexual conversations with girls from the age of 15 while grandfathers do the same with boys. Discussions usually center on areas such as potential sex partners, sex and health issues, and preparation for sex in terms of what to expect from the male partner, how to handle the opposite sex partner, and when to say no to sex. This is how one teenager put it: *"When the girl gets her first menstruation period she has to tell her grand mother or her mother, elder sister, cousin or aunt. Then she will be confined to the hut or room to be taken care of by her grandmother for the whole week or till the period stops. This is the time when you are told that sex with boys will result with pregnancy or sexually transmitted diseases such as gonorrhoea and syphilis."* In addition to sex education participants also mentioned that the girl's first menstruation in this culture is also used to introduce her to traditional health prevention and curative herbal remedies for sexually related health problems or ailments. *"My grandmother smeared cow dung on my waist and back when I had my first menses so that I would not have period pains. She also told me that in our culture women do not engage in sex when they are menstruating because the blood is too hot as it is being shed to purify the female reproductive system."* She added.

Marriage also marks another passage in the sexual life of a woman in this culture. As part of the marriage socialization ritual, the couple goes through another sex training. For instance, sex societal norms are in place to ensure spacing of children. Culturally breast-feeding is done for two years and during this time the lactating mother is not supposed to engage in sex with the husband. If for some reason the woman is not able to breast-feed for two years then they both drink traditional medicine to prevent pregnancy. This is how one woman described her experience, *"A thread is put around the woman's waist with a piece of traditional herb as a reminder to the man that it is not time to have another baby. It is also believed that this herb magically discourages the woman's sexual activity because it will be an embarrassment to the family if the couple can have a baby prematurely."*

Asked who the recommended sex partners were in this culture all participants mentioned that girls were socially meant to accept sex with sister's husband if officially assigned the responsibility of 'Nkadzana.' However, in addition to these cultural sex partners, the younger participants and middle-aged women confessed that because of economic hardships and interaction with people from other cultures some women and men engage in sex with other people. *"This is where our young people get AIDS, they really have to stop sleeping with outsiders. The cemetery is full."* Said one of the elderly grandmothers interviewed. Beyond a certain age if a girl is still not married, a parent especially grandparents, expect their unmarried daughters to have children. This puts pressure on girls and young women to engage in unprotected sex. A grand mother would say, *"At least give me a grandchild. I have no work now. I want to see my great grandchild before I die."*

Data on the relationship between these ethnic sexual practices and HIV/AIDS revealed that women are aware that they are at risk of HIV infection because most men do not agree to use condoms. The following statements are testimony. *"As a wife or Nkadzana how do you even begin to dream of mentioning a condom unless you want to be beaten?"* *"It is hard because men play their part, i.e. feed the family, take care of his in-laws, so all you have to do is to satisfy him sexually, not with a condom."* *"Knowing about HIV/AIDS is not a problem. We all know and we are actually tired of the radio messages about HIV prevention but, in this culture, women have no power when it comes to sexual decision matters."* *"Not only that most men in this culture do not believe in using condoms. They say they develop rash around the male organs when they use condoms. Government should try condoms with boys not their fathers, who knows, maybe the young ones are different."*

Other findings related to HIV/AIDS were the cultural beliefs and misconceptions surrounding the epidemic. Since AIDS symptoms are family ailments people believe that traditional curative and cleansing herbs like *"nshashanyama; mzeze, and mphalola"* should be able to cure AIDS. If not, it means that God is punishing them for something with this epidemic and it will pass just like other epidemics in the past. Although participants on this study realize that women are most vulnerable to HIV infection because of the Nkadzana sexual practice and male power in sexual decision-making, they nevertheless respect their culture and expect the solution for HIV infection to come from within the culture.

### ***Ngwato: Mantsala and Dithogo***

*Mantsala* means playful sex with a blood or ethnic cousin. Although the major Tswana speaking tribes or ethnic groups in Botswana practices this cultural sexual behavior, the Ngwato ethnic group was selected to represent this cultural practice. In their case, sex with sons of mother's brothers or cousins extends to tribal cousins. Culturally the *Bakgatla* ethnic group is the tribal cousin to the Ngwato ethnic group. Furthermore, this ethnic group is also associated with sex favors from nieces to their uncles or *"setlogolo ntsha dithogo."* Data analysis revealed that cultural sex education for this ethnic group includes preparing girls to expect request for sexual favors called *"mantsala"* from three

different categories of men. These are blood male cousins i.e. sons of mother's brothers, tribal cousins from the Bakgatla ethnic group and uncles (i.e. their mother's male siblings) in the form of 'dithogo.' This statement was echoed by all participants from this ethnic group: *"My uncles boys are my God given husbands. So there is no need for them to ask, they simple say cousin its time lets go."* Yet another said, *"I always joke with wives of the sons of my mother's brothers by reminding them that I am the real wife, but they are mothers of my children."* This statement is not surprising because both the socialization and sex education encourages marriage between these family or ethnic relations. Proverbs such as *"ngwana wa ga malome nnyale kgomo di boele sakeng"* or *"my mother's brother's son marries me so that cows get back into the family kraal"* reinforce these unique cultural sexual practices. In Botswana in marriage the husband's family pays 'bogadi' or bride price of a minimum of eight heads of cattle to the wife's family as a token of appreciation for giving a woman who will in turn give them children.

Respondents mentioned that sex with one's uncle seldom happens and it is the best gift a niece can give to her uncle, hence, it could not be protected sex. This is how one middle-aged woman put it: *"It is very rare for an uncle to ask for sex as 'dithogo' so you really look forward to that honor. Most of the time they ask for small things like a shirt, money, shoes but, this is the man who is vested with all the powers in your marriage and responsibility during hardships."*

Men in this ethnic group were also described as responsible for sexual decision matters and not comfortable with the use of condoms. *"Most men do not believe that condoms do not have the HIV virus."* In Botswana there is a widespread belief that if you put water in a condom some worms are seen floating in the water and that is the HIV virus. So condoms are not trusted because of the lubricant and the fact that they do not originate from within the culture. This is how one put it, *"men ask questions such as, where do these condoms come from? I am black or brown and just look at the color (cream white) of the condom, it shows that it is from the West. It is another tactic of wiping Africans from the surface of earth. Unless you show me a factory of condoms in Botswana I can't believe it does not have AIDS."*

Asked about HIV/AIDS it was interesting to know that respondents were aware of symptoms and prevention strategies in place but were quick to say change of sexual behavior was a major challenge. As one put it, *"what they (modern health personnel) propose cannot happen in this culture. How do you abstain from what is part of you? We will just continue using our traditional medicines and cleansing herbs."* *"We can't stop having children. With or without AIDS the pressure from husband and the extended families is beyond women's control in this culture."* Said another. One of the elderly women in this culture emphasized this point: *"In our culture, in marriage two people become one in sickness and in health, this means that if the other person is sick you are also sick. How can I listen to people (western medicine) who do not understand my culture and ask my husband, cousin or any potential marriage partner to use a condom? I must be sick in the head to do that."* Although concerned about the impact of HIV/AIDS, respondents of this study stressed that everybody has to participate in the fight against the epidemic and not just the Government and outside health experts. In



agreement one traditional midwife said: “ *Our traditional doctors and spiritual healers are now realizing that most of our herbs are probably too weak for the HIV virus, so they are referring some patients to the government clinics while working around the clock to identify stronger herbs for this disease.*”

### ***Baherero:Otusira:***

The Baherero ethnic group have a unique sexual practice traditionally associated with the belief that ‘for every member of the clan who dies, there must be *Otusira* or ‘replacement.’ The night before a burial there will be an all night memorial service at the bereaved family’s home to thank the ancestors’ spirits for the life of the deceased and to request for a replacement. However, while the all night service is on, an identified small group of girls from the extended family of the deceased will be available for unprotected sexual encounters with relevant extended-family male members. This is done with the hope that one of the girls will conceive to replace the deceased.

Sex education in this ethnic group is also offered to the young people by grandparents. For the girls it starts after the first menstrual periods. The girl is confined to the room for a week where grandparents tell her about sex, womanhood and how to ensure male sexual pleasure. This initial sex education ends with a big church ceremony held once a year for a cohort of girls. Asked why the church, the response was that in addition to introducing the young women to the community, the religious version of sexuality is given by the church elders in front of the whole congregation.

Another finding from this ethnic group is that one message from the traditional sex education emphasized during traditional religious ceremonies is that HIV/AIDS is incurable because it does not originate from their culture. It is also stressed that sexual activities should be confined to the ethnic group because traditional medicine, spirituality and spirits of the deceased ancestor’s blessings are in place to prevent and cure sexually transmitted disease. As one female youth put it, “*we are told by our grand parents and male sex partners that sex from Moherero to Moherero should be unprotected because you can not be infected with the HIV virus.*” In agreement another said: “*In the urban areas we use condoms with boyfriends from other ethnic groups but with a Moherero boyfriend or cousins in Namibia I enjoy real sex because they will not accept a condom.*”

### ***Barolong:Seantlo:***

‘Seantlo’ or wife/husband inheritance is when a widow or widower marries a sibling of the deceased husband or wife. This Barolong cultural identity has been retained because of this ethnic group’s emphasizes on the need for good parenting especially motherhood. It is believed in this culture that if the wife dies when children are still young, the husband should be encouraged to marry the younger sister to the deceased wife because culturally she is the younger mother “*mmangwane*” and, naturally, she will take good care of her deceased sister. Another rationale is that if the deceased was a good wife and a good daughter-in-law there is no need to end the two family’s good relationships. This statement was echoed by most respondents, “*remember in our culture we say that a family has married so-and- so’s daughter. Even the socialization of the new bride*

*stresses the importance of her understanding that she is marrying the husband's family not an individual in that family.*" Furthermore, discussions with the elderly female respondents revealed that this sex practice was enforced when the ethnic group settled in Botswana as a way of ensuring that the family will have the labor needed for arable production. Even more importantly it was the most appropriate for controlling sexually transmitted diseases. This is how one respondent explained the rationale: *"When you settle at a foreign place, there is a lot to do i.e. build homes, clear the land, plant crops and ensure a good harvest, so there is no time for health care. In that case sex with foreigners had to be avoided and discouraged, and this cultural sexual practice was most relevant to retain."* Barolong are found along the border of Botswana and South Africa. In spite of official border restriction, close proximity of the Barolong in Botswana and those in Mafikeng (South Africa) allowed for the necessary regular interactions including 'seantlo' with the rest of the ethnic group population across the border.

### ***Basarwa: Xakanaxaamaa***

The Basarwa ethnic group has the sexual practice of multiple partners, which serves an important social function. This culture condones a woman having sex with any man as long as they leave a spear at the door to alert other men of their presence. Due to the traditional nomadic culture of the Basarwa, it is believed that every woman needs protection from the hostile environment, especially in relation to wild animals. The male who provides this service in return has access to sexual favors. During the data collection it was observed that Basarwa move around in gender pairs (man and woman). For example, respondents from this ethnic group were interviewed in front of their male partners. These comments were made by both men and women behind each other's back during data collection: *"You don't know Basarwa men, he won't go far because he does not want other men to have sex with me."* said one female respondent. On the other hand a male partner who allowed the researcher to interview his sex partner said, *"Basarwa women are very slippery because they love sex. That is why I will not go far when you interview her."*

Data from interviews with Basarwa women revealed that in the Basarwa culture every man is a potential sex partner and sex can be done any time at any place. Because traditionally Basarwa move around in a group or clan, at night men leave spears outside the huts to indicate to other men that the woman in this hut is safe. If there is no spear then any man can enter and spend the night with this woman. Women understand that this protection is offered in exchange for sexual favors. Socialization and sex education is in place for this ethnic group. The focus of this education for women is on how to give the man pleasure such that he would marry you or be with you for a longer period. They also mentioned that health education focuses on sex taboos and herbs for prevention of sexually transmitted diseases.

Most respondents from this ethnic group did not know much about HIV/AIDS even though they had observed that death had increased. Those who had heard about it thought it were a disease from other ethnic groups. *"If some Basarwa girls were not sleeping with Bangwato we would not have AIDS in our community because Basarwa*

*traditional doctors are very good with sexually transmitted ailments and prevention herbs.”* Data from this ethnic group also show that there was no secrecy or stigma associated with sexually transmitted diseases. The elderly (no longer sexually active) members of the community have the responsibility of ensuring that sexually transmitted diseases are detected early and treated by traditional doctors. For example, when the young sex partners have an infection they both take the prescribed treatment and are not supposed to have sex. The male sex partner sleeps with the eldest man when on medication and his female partner spends the nights with an elderly woman. “*It is important that the whole clan knows that these two are sick so that none of them spreads the disease through sex.*” said one of the elderly women interviewed.

## **Understanding sexuality from its own cultural perspective**

The culture dimension of sexuality described in the earlier section show that sex has a social function and it informs gender identity. For instance, in the above section it is clear that for every ethnic group sex is regulated by the family and society because of its diverse roles that include procreation, pleasure, family property, exchange, personal interaction, healing/cleansing, religion/spirituality and control/oppression. Sex social roles that emerged from the findings of this study are discussed in this section. It is important to analyze and understand each culture from its own perspective because ideas on HIV/AIDS intervention have to take into account cultural realities and avoid the transfer of HIV/AIDS definitions and understanding based on different experiences.

**Sex as procreation:** One social function of sex in the Botswana culture is that marriage is primarily a union for the production of children. As evidenced by the *Nkazana* and *seantlo* or wife inheritance, sexual behavior is not ignored in society. In fact because of this social function the sexual life of married people is affected not merely by individual desires and varying proficiency in the art of making love but by both the family and societal sex regulations. For instance, a man whose wife has given birth must abstain from sex until he has resumed sex with his wife by “crossing the poles” i.e. believed that failure to do this will cause the newborn to be stupid or ‘*mopakwane,*’ or grow weak and deformed. It is important to mention here that these customary restrictions are based upon locally accepted ideas of disease or other misfortune caused by wrongful indulgence in sex. This confirms the literature on married life in Africa (Schapera, 1971) showing that sex is considered a normal fact of human life and Christian mission teaching has not succeeded in tarnishing these cultural sexual practices with concepts of shame and sin.

Based on the central importance of producing children, traditional education institutions like the family and initiation ceremonies prepare boys and girls for this role prior to puberty by teaching them how, when and with whom to engage or avoid sexual relations. So very few young people enter marriage with no sexual experience at all because once past puberty girls and boys engage freely in full sexual relations so that by the time they are married they will have acquired personal experience of intercourse. Therefore, an HIV/AIDS strategy that emphasizes abstinence for this age group is definitely not

culture-sensitive. Furthermore, the polygamous ideal still prevails as evidenced by sexual practices like *Nkazana* and *Seantlo* in spite of monogamy encouraged by both Christian religion and government marriage legislation. Furthermore, procreation use remains a cultural priority. For example, if a husband stays away too long from his wife, public opinion will not condemn her for taking a lover by whom she can bear children.

The desire to have children is also reflected in the various ethnic sexual customs. The rationale is related to addressing barrenness in marriage. For example, an impotent husband may place his wife at the disposal of some intimate friend or relative just to have a child. Similarly, if the problem lies with her, she may procure another woman from the family to bear him children thus saving the marriage. Because of the use of Christianity cultural lenses this custom is considered immoral and forbidden for church members.

**Sex as pleasure:** Another social role of sex in these cultures studied is that it gives great pleasure and entertainment. For example, in marriage it is the duty of the wife to give the husband carnal satisfaction and no attempt is made to disguise this. The youth interviewed in this study mentioned that the traditional sex education and experience they received from family members and sex partners taught them how to prevent conception because children are for married people. Participants of this study said girls are taught by their mothers, grandmothers and practically by sons of mother's brothers how to tilt the hip to facilitate outside ejaculation. Another method is urinating immediately after engaging in sex to get rid of semen. Sex with cousins, uncles, stepfathers and boyfriends is testimony that sex is also used as entertainment. It is important to understand this cultural dimension of sex for HIV/AIDS prevention because it has a direct bearing on one message of the current ABC HIV strategy, namely, '*be faithful to one partner.*' Although the social function of sex as pleasure/game/fun is likely to expose the youth to sex with multiple partners, however, it also gives them an opportunity to explore by themselves or with playmates of either sex until they are old enough to have babies. Hubbard (1995) argues that in the HIV/AIDS era adolescents who have some sense of their own sexuality and other peoples needs are likely to know how to talk about sexuality and procreation with friends which is essential for preventive hygiene.

**Sex as family property:** Based on the role of the family in an individual's sexual practice, it is concluded that another social function in these cultures is sex as family asset. For instance, men or boys who impregnate girls (only with the first child) pay the girl's family eight head of cattle or money equivalent for what they call '*tshenyo*' or damages. The charge is less if the male is a family member. On the other hand in marriage the family of the bride gets '*bogadi*' or bride price from the husband's family as a token of appreciation for having given them a wife. Similarly, the husband of the wife also charges a man who sleeps with his wife outside the cultural arrangements but the couple raises the child as their own.

**Sex as an exchange:** Although wife inheritance is likely to be forbidden by churches to their members, the data shows some ethnic groups practice it because of both economic and the social responsibility of the female gender. For instance, supporting a

widow and her children is the responsibility of the deceased husband's family and if necessary this is provided in exchange for sexual favours with the male relative. The "*setlogolo ntsha dithogo*" or sex with mother's brother is also done in exchange for the fatherly responsibility assigned to the uncle. Due to economic hardships that have resulted in poverty and lack of employment opportunities, the youth and single women in particular mentioned that they engage in unprotected sex outside the family in exchange for money and other basic services. Discussions with participants of this study on their male sex partner's reluctance to use condoms revealed that the act of intercourse itself is an exchange. This is how one middle-aged woman put it: "*I am a single parent with three children. I am lucky to have a boyfriend who gives me soap (i.e. money). You know why he does that, it is because we don't use a condom and he realizes that I need soap to wash his semen. Now if we use a condom there will be no need for soap because he simply throws away the condom with his semen.*"

**Sex as social interaction:** Although sex in marriage is between two individuals, however, the fact that their sexual relation has been authorized by the family and societal structures influences how members of the two families (wife's family and husband's family) and even their ethnic groups are going to interact and relate to each other on a day to day basis. For example, not only do the two families become one but also they begin to abide by certain social norms and expectations. The ethnic cousin sexual practice among both the *Bangwato* and the *Bakgatla* groups is another level of sex relations that comes with social expectations and trust. The '*Nkazana*' and '*Seantlo*' also emphasize a relationship based on good parenting and or the responsibility of procreation. On the other hand the blood cousin and uncle to niece sex or '*mantsala*' and '*setlogolo ntsha dithogo*' are in place to provide the necessary sexual experience required for a good marriage.

**Sex as cleansing and healing:** One sexual practice represented by the different cultural dimensions of sexuality is inter-generational sex or sex between young women or girls with an older male sex partner. This happens because of the cultural belief that sex with young girls cleanses men's reproductive systems while menstruation and birth cleanses the female reproductive system. The withdrawal method is used not only to prevent pregnancy but also to "spill the hot blood." In the HIV/AIDS era this cultural practice could encourage sex with multiple partners thus increasing the spread of the HIV virus.

The restrictions and regulation of sexual intercourse described by these ethnic groups are associated with the belief that at certain time a person's blood is hot (i.e. semen or vaginal discharge) and until they have cooled down both are in a condition to be harmful to others. For example, a woman is hot during menstrual periods and after an abortion, widows and widowers are hot for a year after their bereavement or '*boswagadi*', a traditional doctor is hot for three days after one of his patient dies. Hotness resulting from sexual behavior itself is believed to indicate that if the person affected indulges in intercourse before cooling down his partner will be stricken with disease and may die.

All ethnic groups reported that they use traditional medicine and herbs to purify the blood and to remove sexually transmitted infections. Healing is another important social function of sex described by the different ethnic groups that participated in this study. In addition to drinking herbs such as purgatives, grapple plant, etc. for cleansing the blood, sex is also denied while on treatment for sexually transmitted diseases (STD's). It is important to mention that participants reported that traditionally there was no stigma or secrecy associated with sexually transmitted diseases or any disease for that matter as compared with what they have observed with HIV and AIDS. This finding supports the literature (Mutula, 2002) on traditional medicine in the region that shows that local herbs, roots, barks and leaves collected from the wild have been identified as key sources in traditional medicine. According to Mutula, (2002) 'matera media' is an indigenous medicine which was used in the 1918 for global influenza and today it plays a major role for the relief of wasting and TB both exacerbated by AIDS.

The cleansing and healing social function of sex seems to have placed a lot of power on the family in enforcing all prevention and curative health aspects. The data revealed that in the past this role was done successfully under the supervision of the family for all ethnic groups. Unfortunately with HIV/AIDS the family's involvement was overlooked until very late with the introduction of the home-based care program whose prevention strategy of hand gloves has met resistance just like the use of condoms. Culturally love is shown when the other person is sick; hence the HIV prevention message of using gloves when handling sick family members is perceived as silly, and even worse, insulting to the culture.

**Sex as religion/spirituality:** As seen with the Baherero (*Otusira*) sex, is also controlled by indigenous religion and spirituality. Religious believes such as those of Baherero condone polygamy as a way of regulating sex and confining it to the ethnic group. We also saw with this ethnic group how sex is connected to the spirits. The connection of the dead and the living through sex is something that needs further investigation as it gives a different focus from the conventional religion as portrayed by western Christianity. Ignoring culture-specific religion/spirituality in the fight against HIV and AIDS in some cultures could be a big mistake. After all, monogamy as enforced by Christianity and government legislation has not been accompanied by the true companionship upon which a successful union should rest. Although traditional African religion, as evidenced by the Baherero religion support polygamy, they would be quick to mention that taboos are in place to regulate sex and prevent sexually transmitted diseases. Baherero religious sex education ceremonies can be used for an effective HIV/AIDS prevention.

**Sex as mean of control/oppression:** From the gender perspective, the sexual practices and behavior described by the five ethnic groups fit the definition of sexuality provided by Jackson (2002) who states, "sexuality refers to the aspects of gender identity that relate to sex. As far as sexual behavior is concerned, men in many societies can be proud of having multiple partners because it shows their sexual prowess. But for women sex is predominantly about pleasing men, essentially her husband, and about having babies. Hence sexuality often refers to male needs and desires, while women's sexuality

is looked down on, ignored or feared and repressed “ (p. 88). Although women in these cultures might not see this as oppression or even control, some of these statements made suggest the contrary: “*Men in this culture decide on how they want their sex.*” said one woman. “*Having access to condoms and knowing how to use them is not helping us women because if you bring the condoms to a Motswana man he calls you a prostitute.*” said another.

## **Challenges and opportunities for empowerment**

As an adult education practitioner, I have learnt that if education and prevention programs are to be successful they have to be informed by culture because groups of people experience the world differently. Unfortunately, in Botswana the initial reactions of public health authorities to the AIDS epidemic was to persuade individuals to change their behavior by providing them with what they thought was relevant HIV/AIDS information and tools. For instance, people were told that HIV/AIDS was deadly and had no cure. But they could prevent themselves from the HIV virus infection by abstaining from sex completely (A), being faith-full to one sex-partner if one cannot abstain such as those in marriage (B) and using a condom in the case of multiple partners. This has proved to be an ineffective strategy. Fishbein and Middlestadt (1989) argued that, “*the AIDS epidemic is too serious to allow interventions to be based on some educator’s untested and all too often incorrect intuitions about factors that will influence the performance or nonperformance of a given behavior in a given population*” (p. 109). Based on this theoretical understanding and the findings of this study, it is clear that an understanding and appreciation of individual’s intentions, beliefs, attitudes, norms as well as emotional and cultural components is paramount for any behavior change strategy. Thus, the next section identifies the challenges and opportunities for HIV/AIDS prevention posed by considering the cultural dimensions of sexuality.

### **Challenges for empowerment:**

Based on the situation of HIV infection in Botswana there is need for sexual behavioral change. The key question is how to achieve that given the social functions of sex, which promote unprotected sex with multiple partners. It is argued that unless the following challenges are addressed in a participatory way, behavioral change will only remain a dream in the Botswana context.

Resistance to the use of condom: Data from this study revealed that ethnic groups studied are very proud of their unique cultures. They have created a defensive mechanism for any criticism of their society and they do not want to change their culture or societal system. For instance, in spite of the escalating prevalence rate (from 18% in 1992 to 36% in 2003) in Botswana, the most recent surveillance report shows worrisome findings related to HIV/AIDS knowledge, attitudes and behavior. For example, 68% of the young men and 78.1 % of the young women (aged 15-24) do not believe it was reasonable to expect people to use a condom for every sexual encounter.(Campbell and Rakgoasi 2002). So resistance to the use of condom poses a big challenge for

empowerment activities for HIV/AIDS prevention where most people are not going to abstain or be faithful to one partner.

Western Versus Indigenous medicine and healing: This is a challenge because not only are the traditional healers very influential but also access to traditional medicine and information is locally available and affordable. The advantage of indigenous medicine is that it draws on local resources, thus making people less dependent on outside supplies that can be costly, scarce and irregularly unavailable. Currently people are using affordable medical plants and herbal treatment to address opportunistic infections. For example, traditionally unprocessed food supported the preventative medicine, but now with western influence and globalization food bought from grocery stores has resulted in food shortages and processed food with reduced nutritional value. Due to food shortage food sharing is either reduced or is not practiced anymore with a large extended family. Even worse, food is over processed. The negative is that cultural ties are dying especially in urban areas and societies are losing traditional practices that would be helping to address HIV/AIDS, such as nutrition and family support.

Gender-based poverty: Women are vulnerable to HIV/AIDS not only because of cultural issues but also because of poverty. Women and children are vulnerable to HIV/AIDS and abuse because of their economic vulnerability. For instance, they form the bulk of the poor section of the population most affected by high rates of unemployment or under employment. Due to low levels of education, women are usually the first to go in any economic recession and retrenchment exercise. Economic hardships in the rural areas is pushing young women to the urban areas in search of employment where they venture into sex work as the last hope for survival. In the rural areas, the social function of sexual relations has always worked to reduce the effects of poverty because sharing is pronounced in extended families. A good example is the hand-me-down system of clothing that is respected and crucial for family ties. Food is also shared because children are shared and raised by the extended family.

Changing the social conditions for young girls: Empowering women, especially young girls, to negotiate for safer sex and to have the ability to control their sexuality in a patriarchal framework will be a big challenge for HIV/AIDS prevention efforts. This is so because it implies changing the social conditions that deny young women the ability to control practices that increase their vulnerability for contracting HIV. Currently about half of the youth in Botswana are sexually active by age 20 with the median of initial intercourse being 17 years (Campbell and Rakgoasi, 2002)

Mobility of multiple sex partners: This is another challenge because sex partners are no longer confined to the village due to economic hardships in the rural areas. For example, it was reported that some of the Baherero sex partners are in Namibia while others work in urban areas of Botswana. The question to be answered by any relevant HIV/AIDS empowerment strategy is 'what do we do about the social function of sex in the HIV/AIDS era? 'These cultural sexual practices are used to ensure that the family is a strong institution whose role extends to making it possible to prevent the spread of sexually transmitted diseases. What do we continue with and what do we alter and who decides?'



## **Opportunities for empowerment from within existing culture discourses**

After understanding sexual practices from their own cultural perspectives, it is now possible to identify and discuss opportunities for empowerment in what could actually be a hopeless situation from other peoples' cultural lenses. This section discusses the opportunities for empowerment in Botswana cultural contexts:

Collective sexual responsibility: The fact that both the family and society plays a key role in sexual matters and the respect for its culture by all ethnic groups in Botswana is an advantage that should be tapped for effective HIV/AIDS prevention strategies. The importance and power of the family is not unique to the cultural dimensions of sexuality in the context of Botswana. Caulfield (1993) shows that it is actually a defining characteristic of African culture. This study has shown that in Botswana a woman's place in social life is not in any direct sense a product of the things she does, but rather the meaning her activities acquire through social interaction. Therefore, the family should be crucial in women's health and empowerment.

Traditional sex education structures: Given that the current HIV/AIDS information, education and communication are perceived as externally imposed and culturally alienating. Understanding of health and sexuality, traditional sex education can be analyzed to identify indigenous role models. For example, menstruation rituals, annual sexual education ceremonies, and religious sex education activities can be used to mainstream HIV/AIDS prevention.

Participatory approaches: Botswana is known for its effective democratic values such as collective consensus, respect for ideas and opinions shared at the village parliament or '*Kgotla*.' This participatory approach is a strength that can be used to engage people in critical reflection in relation to the impact of global development agendas on their unique indigenous health culture, prevention and curative medicines including HIV/AIDS prevention. This will not only be in line with the cultural decision-making process but also facilitate family and community ownership and commitment to processes identified and agreed upon.

Role of Traditional Healers: Because of their influence in the health of families and societies, traditional healers can be used in strengthening community-based HIV/AIDS health care systems such as that of addressing opportunistic infections and peer counseling. The fact that they have registered their concern about being excluded in HIV/AIDS matters means they are ready and concerned with HIV problem too.

## **Recommended focus of empowerment for HIV prevention**

Kindervatter (1979) defines empowerment as “people gaining an understanding and control over social, economic, and/or political forces to improve their standing in community. Participation has also been linked to empowerment as a way of encouraging people, especially the public to see themselves and their role as relevant and indispensable in community activities. Dean (1999) argues that for people to be active in their own development, they must be given power that connotes respect for and the use of local knowledge, experiences and interest. Informed by this discourse, it is argued in this section of the paper that in the absence of a cure, behavioral change is key to reducing the incidence of HIV transmission. Furthermore, there is need for an alternative HIV prevention strategy that will be based and informed by a relevant empowerment program. Adult education with its learner-centered approaches that emphasize participation and self reflection as well as the belief that adults learners abundant experience is the greatest resources is perceived as the most relevant for helping the Batswana to empower themselves to effectively redress the escalating HIV infection rates in their context.

1. Empower women: Women know a lot about HIV/AIDS but that knowledge is not being used because of their powerless status in decision-making matters about sexuality. Given that HIV/AIDS prevention strategies have focused on providing HIV/AIDS information based on Christian morality and western scientific knowledge without recognition of African women’s limited economic empowerment, these strategies have not been effective. It is therefore recommended that future HIV/AIDS empowerment programs should be target specific and context based. There are many conferences on HIV/AIDS prevention but participants are educated elites, in-school youth and female workers. It is recommended that a shift of focus should be towards village women in their localities, the out of school youth and the younger youth (10-15). These are the most vulnerable groups in society because they are the ones most immersed in cultural education, values, beliefs and expectations.
2. Empower men for HIV/AIDS prevention: In patriarchal societies like the ones described, men have a dual role. They are not just leaders, policy makers, decision-makers in matters of sex, but they are also sex clients in an environment conducive for the spread of the HIV virus. For instance, as “*Nkazana*,” “*mantsala*,” “*seantlo*,” and “*setlogolo*,” they have not been reached by HIV/AIDS information and prevention strategies. It is therefore recommended that HIV/AIDS empowerment programs should promote men’s understanding of their role and responsibility with regard to protecting women’s health and reducing the transmission of sexually transmitted diseases including HIV/AIDS. This is in line with their cultural role of provider and protector of the female gender. The push for human rights and women’s right advocated for by those from the women-only gender perspective will not give the required immediate results from the prevention activities. As behavior change theorists rightly point

out, before anyone can change their behavior they need to know and realize the need to change behavior and this is always done in relation to one's cultural values and beliefs. Therefore, it is important to empower the men to dictate safe sex practices.

3. Use other groups of people in the fight against HIV/AIDS: It is important for every one to participate in the relevant education on HIV/AIDS because everybody is not only vulnerable but also responsible for the spread of the virus. It is recommended that the alternative strategy to the current ABC message in Botswana be a product of critical reflection, planning, prioritizing, and implementing exercise traditional participatory approaches with communities. For example, involvement of traditional doctors, spiritual healers, men's groups, women's groups, youth groups.
4. Work with traditional doctors: There is need to work with the most influential and effective health educators, namely, traditional doctors because they are part of the solution. I believe that the more we listen to them, the more they will listen. For example, AIDS testing centers should create time to understand and check if it is possible to test for HIV infection through traditional processes. One of the female traditional doctors interviewed registered her complaint thus, *"we have not been fully involved in the fight against AIDS, we refer patients to the modern medical doctors but they never refer patients to us. Is it because they look down upon our practice? They better remember that they (white doctors) and their pills found us here and our patients know better. That is why they still come to us."*
5. No condoms: Because of existing cultural beliefs and values, it may be difficult to encourage the use of condoms. It is therefore recommended that existing cultural forms of sexual intercourse should be investigated and encouraged where possible. It has to be realized that the social functions of sex such as those of procreation, and the interconnectedness of spirits of the living and the dead may be far more important than the risk of HIV infection which may or may not kill you after two years.
6. Research: Is needed to identify indigenous knowledge systems, traditional sex education and their relevance to empowerment activities for HIV and AIDS prevention. For example, given the importance of testing for infectious and sexually transmitted diseases, studies on the relationship between traditional medicine and testing could identify appropriate methods of encouraging HIV/AIDS testing for early detection and treatment. Similarly, studies on cultural beliefs and sex education could be useful for identifying cultural norms that can be kept for cultural identity but change or replace sex practices that encourage HIV infection with those that will control the spread of the virus through unprotected sex. For example, both the blood and tribal cousin relationships could be kept but if collectively acceptable, the sexual encounter could be replaced with material gifts instead.

## **Conclusion**

Findings of this study have confirmed that sexuality and sexual behavior in particular is not just a biological but also a social construct. The social function of sex demonstrated by five different cultural sexual practices are sex as procreation, pleasure, relations, family property, religion and healing. The study has also revealed that in addition to regulating sex cultures also have effective indigenous sex and health education strategies that both socialize members by providing common understandings in the form of taboos and proverbs.

An assessment of the Botswana current HIV/AIDS prevention strategy show high levels of public information and messages to Abstain, Be faithful, and use Condoms (ABC). However, results of this study revealed that the ABC strategy is ineffective because condoms are not used or at best are used inconsistently because of its conflict with traditional sex education and practices. Furthermore, there are high levels of mistrust about the information being provided and its lack of synchronicity with cultural beliefs and values. Decision-making regarding sexual practices is out of the hands of women and girls because both did not realize that they have the right to say no to the male gender in their context.

Although behavioral change is still crucial for HIV prevention in Botswana, however, there is need for an alternative strategy because the ABC strategy is not appropriate for the Botswana sexual cultural context. It is recommended that the alternative strategy be context and target specific by embracing and being informed by cultural sex and health education. Also empowerment strategies should focus on the family instead of the individual and it is important to use participatory methods of planning and delivery of prevention activities because of the collective and consensus nature of society in Botswana.

Furthermore, to address the HIV/AIDS epidemic, there is need for appropriate and relevant empowerment skills for both men and women. Women in particular should have the courage to negotiate for safer sex in a context of inter-generational sex. The fact that men have the responsibility of providing economic and material things to women and are also decision-makers in sexual matters, this is a strength that can be used for HIV and AIDS prevention. It is recommended that men be empowered to realize that as decision-makers in sexuality issues. They have to lead in the fight against HIV and AIDS in the family and sexual relationships. Finally, research is needed to identify relevant indigenous knowledge systems, appropriate traditional sex education content as well as training methods and their relevance to empowerment activities for HIV and AIDS prevention.

Overall, the findings of this study have demonstrated that HIV/AIDS prevention strategies would not be based in standardized, universal IEC approaches such as ABC but on adult education that seeks to be culturally specific and one that will mobilize people to seek solutions within their own diverse cultural contexts.

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