

IV. BOTSWANA PHR STUDY FINDINGS

This chapter presents the most significant results from the Botswana community survey and PLWA interviews. Key findings include:

1) *Participant Characteristics*: More women than men surveyed reported food insufficiency, lower incomes, greater likelihood of unemployment and having at least one dependent. Lack of food and women's economic dependence on men also affect many PLWA and are a particularly salient barrier to ARV treatment.

2) *Knowledge of HIV*: The majority of community survey participants correctly answered questions about HIV prevention and transmission. Common gaps in knowledge and misconceptions persist, however. PLWA described men's knowledge as inferior to women's.

3) *HIV Testing*: While the majority survey reported access to testing, 52 percent of women and 44 percent of men sampled had tested. Media messages were the most common facilitators to testing and fear of knowing one's status the most common barrier for both women and men. While the majority had voluntary and confidential tests and received pre- and post-counseling, 62 percent of women and 76 percent of men reported that they perceived that they could not refuse the test.

4) *Routine Testing*: Fifty-four percent of respondents had heard of Botswana's "routine testing" policy before the survey and 15 percent of those tested had tested under this opt-out program. After an explanation of the policy, the majority expressed positive views about its impacts, though 43 percent agreed that routine testing could cause people to avoid health care for fear of being tested. PLWA agreed that routine testing could facilitate increases in testing; they expressed the concern that counseling be assured so that recipients will be prepared to learn their HIV status.

5) *HIV-Related Stigma and Discrimination*: Fifty-four percent of women and 51 percent of men surveyed reported stigmatizing or discriminatory views toward PLWA. While the majority expressed acceptance of those living with HIV/AIDS and felt that discrimination had declined in Botswana since the advent of ARV treatment, projected fear of stigma should they themselves be HIV-positive was a common concern. For example, 50 percent of women and 57 percent of men reported

that they would be treated as social outcast by their community. PLWA interviewed believed that stigma and discrimination had lessened over time in Botswana and reported positive consequences of disclosure of their status. Nevertheless, those interviewed recounted poor treatment at home, in the workplace and in the community, particularly for women, which they associated with overall gender inequality in Botswana.

6) *Sexual Risk*: Women participating in the community survey lacked control over the decision of when to have sex (30 percent) or use a condom (22 percent) as compared with men (less than 2 percent and 7 percent, respectively). Fifty-three percent of women, and 13 percent of men, had unprotected sex at least once in the past year because their spouse or partner refused to use a condom. Eleven percent had unprotected sex with a non-primary partner. Twenty-five percent of women and 40 percent of men reported multiple sexual partners in the past year; 8 percent of women and less than 5 percent of men reported no partners. PLWA reported having fewer sexual partners and using condoms more consistently since discovering their HIV-positive status; women's lack of control mitigated against such changes for many women.

7) *Gender Discriminatory Beliefs*: 95 percent of women and 90 percent of men surveyed held at least one gender discriminatory belief and the majority reported 1 to 2. While participants endorsed women's subservience to men, 88 percent of women and 84 percent of men agreed that women should have the same legal rights as men in Botswana. Holding gender discriminatory beliefs predicted sexual risk. For example, community survey participants who held three or more such beliefs had 2.7 times the odds of those who held fewer beliefs of having had unprotected sex in the past year with a non-primary partner. PLWA testimony highlighted the association of women's dependency on male partners with their vulnerability to HIV and reported on the ongoing harm to female PLWA created by women's lesser social and economic status in Botswana.

8) *Leadership on HIV/AIDS*: Community survey participants identified gaps in the performance of leaders at all levels. PLWA gave mixed reviews, highlighting the

need for increased visibility and consistent effort, particularly at the local level.

Throughout this chapter, where sex differences are statistically significant ($p < 0.05$), the sex stratified data are presented.

Characteristics of Study Participants

Community Survey

Descriptors of the participants in the community survey, disaggregated by sex, are presented in Table 1. For this study, 1,268 women and men from the five districts in Botswana with the highest number of HIV-infected peo-

ple were surveyed.³⁹³ Fifty-two percent of participants were women. The mean age of those surveyed was 28.7 years; age differences between women and men were not statistically significant. The women surveyed experienced more food insufficiency and were poorer than the men. Twenty-eight percent of women, in contrast with 19 percent of men, reported problems obtaining food to eat in the past year. Fifty percent of women, as compared with 39 percent of men, had a monthly household income of less than or equal to 1,000 Botswana *pula* (approximately US\$220).³⁹⁴ Women were also more likely to be unemployed: 34 percent of women and 27 percent of men reported that they were not working.

TABLE 1: Characteristics of Participants in the Botswana Community Survey (N=1268)*

Community Survey Participant Characteristics	Women (N=654) n(%) (except as noted)	Men (N=613) n(%) (except as noted)	p values**
Age (mean, years)	28.9	28.4	---
Marital Status			
Married	136(21)	105(17)	0.009
Unmarried/Living w/ Sexual Partner	191(29)	149(24)	
Unmarried/Not living w/Sexual Partner	326(50)	358(59)	
Dependents			
Having > or = 1 Dependent	440(73)	325(60)	0.000
Employment Status			
Employed	423(66)	443(73)	0.000
Unemployed	222(34)	165(27)	
Residence Type			
Urban	310(47)	247(40)	0.027
Urban village	187(29)	187(31)	
Rural	157(24)	179(29)	
Monthly Household Income			
< or = 1,000 Botswana pula (approximately US\$220)	326(50)	242(39)	0.000
> 1,000 Botswana pula	321(50)	371(61)	
Education			
< High School (Form 5) Education	301(46)	271(45)	0.572
> or = High School (Form 5)	349(54)	335(55)	
Food Insufficiency			
Problems getting enough to eat, past 12 months	184(28)	113(19)	0.000
Access to Good Quality*** Medical Services	495(77)	530(88)	0.000
Positive Screen for Depression****	190(31)	175(27)	0.096

* Sex was missing for one individual; for sex-stratified data, N=1267.

** P values refer to the statistical significance of the difference between women's and men's responses.

*** This term was not defined for survey participants.

**** Symptoms of depression were measured using the 15-item Hopkins Symptom Checklist for Depression (HSCL-D). People were considered to screen positive for depression if their score equaled or exceeded the cutoff threshold of 1.75.³⁹⁵

Fifty percent of women and 59 percent of men were unmarried and not living with a sexual partner. Seventy-three percent of women and 60 percent of men had one or more dependents. Close to 46 percent of those sampled had less than a Form 5 (high school) education. Forty-seven percent of women and 40 percent of men lived in an urban area, 24 percent of women and 29 percent of men were rural residents and 29 percent of women and 31 percent of men resided in urban villages (urbanized areas outside of main cities).³⁹⁶

The majority of participants in the survey had access to health services, primarily receiving care at public clinics. Ninety-one percent of women and men reported that they were usually treated with respect and dignity by health care professionals. Thirty-one percent of men self-assessed fair or poor health status, as compared with 27 percent of women; women reported a greater number of visits to a medical doctor in the past year.³⁹⁷ Nearly a third of those surveyed screened positive for depression.

PLWA Interviews

The 24 qualitative interview respondents were all HIV-positive members, leaders, volunteers or counselors with support groups for people infected or affected with HIV/AIDS from Gaborone, Serowe and the surrounding villages and rural areas. Twenty-one were women, in part reflecting the predominance of women in these groups. The mean age was 32 years. Two respondents were married, 3 co-habited with a sexual partner and 19 (including 2 out of the 3 men) were living alone and did not have a regular intimate partner. Only 4 participants had completed high school.³⁹⁸ Nineteen were unemployed. Of those 5 individuals who were employed, all had jobs in HIV-related activities, as counselors, administrators, field workers or cleaning staff.

Access to ARV Treatment

Community Survey

Eighty-five percent of women and 90 percent of men projected that ARV treatment would be available to them should they develop AIDS.

PLWA Interviews

Twenty-three of the 24 participants in the qualitative interviews were receiving ARV treatment. None reported difficulty in adhering to the regime. Interviewees described, however, that barriers to treatment still exist for many who need it. In particular, the lack of

food and gender inequality in relationships create obstacles for PLWA seeking to obtain ARVs.

Barrier to Treatment: Food Insufficiency

Interviewees reported that for Botswana women and men, even before testing positive for HIV, lack of food was a problem. Food insufficiency is compounded by the demands of the disease and the treatment regimen. One 42 year-old housewife from Kopong, herself not receiving ARVs (due to lack of resources for transport), said, “[l]ack of food is a problem. ARVs increase the appetite. If there is not enough food, it is a problem.” Another woman, from the Gabane PLWA support group, noted that once people tested HIV-positive, if they met the criteria for ARV treatment they were eligible to receive a food basket once a month through the government’s home-based care program. Reportedly, “[s]ome people go for the test for the food basket. They don’t want any further ARV assistance.” A similar story was mentioned by a 37 year-old woman interviewed in Serowe:

Seven men went to Tebelopele, one was negative. He wanted to test positive to get the home-based care ration. Most people are still starving.

Even if the HIV-positive individual her/himself is given food assistance, she or he will often share it with relatives, as one 39 year-old man living with his HIV-positive 4 year-old son explained:

Food is given at the hospice, there is also food from home-based care, but they do not give for my son. There is not enough food for my son.

Barrier to Treatment: Gender Inequality

A 32 year-old woman who works with the Botswana Network of People Living with HIV and AIDS (BONEPWA), the national network of HIV/AIDS support groups, noted the fear of abandonment by men that keeps some women from seeking ARVs:

Women don’t take treatment. They are brave for the test, but not for treatment because men, their partner, will find out [that they are HIV-positive]. Women are afraid of losing their partner.

In other instances, women may be denied treatment by their male partners. A 28 year-old man from Serowe who credits ARVs for saving his life reported:

Last time I was at the clinic, I saw a woman who said that her boyfriend took the medicine and threw them away. ... I don’t know why he threw them away. ...It does happen.

Control of access to life-saving treatment is a stark example of the control men exert over women's lives in Botswana in general, as discussed elsewhere in this report.

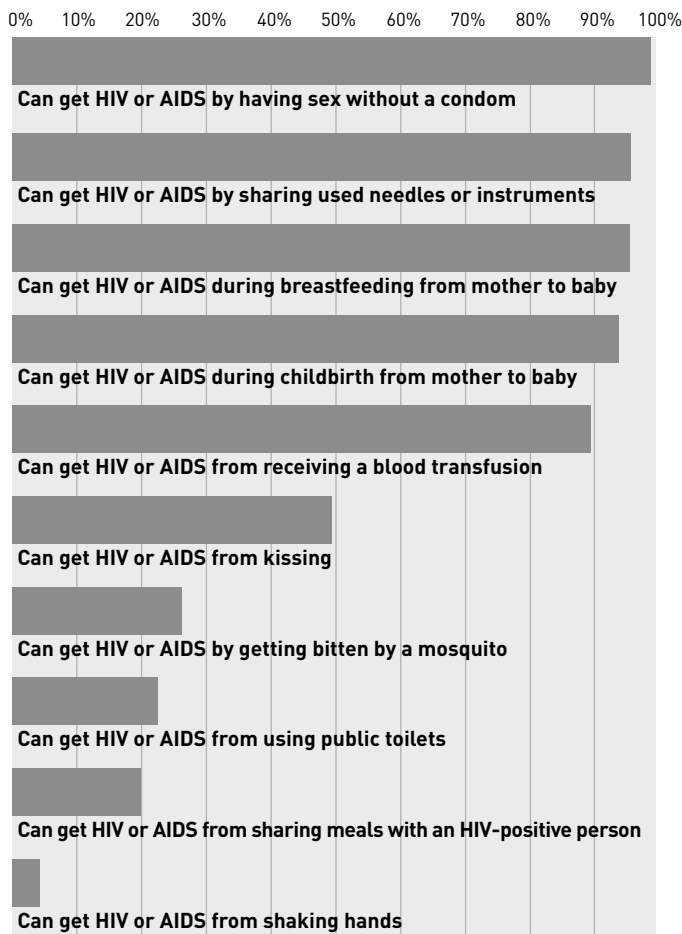
HIV Knowledge

Participants in the community survey were questioned about their knowledge of HIV/AIDS transmission and prevention. Common gaps in knowledge and misconceptions about HIV/AIDS were also discussed in the interviews with PLWA. While the majority reported correct knowledge of HIV/AIDS, the results indicate that potentially life-threatening mistaken beliefs persist concerning both the transmission and prevention of HIV in Botswana, despite extensive national public education and mobilization campaigns.

Community Survey

The vast majority correctly answered questions concerning modes of HIV prevention and transmission,³⁹⁹

GRAPH 1: Beliefs Regarding HIV Transmission, Botswana Community Survey



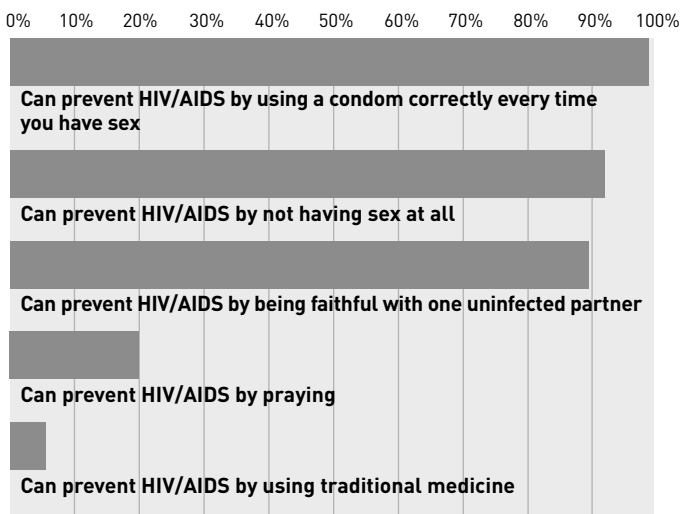
although lower proportions of women (82 percent) than men (89 percent) met this standard. This was found despite women's purported greater access to information through the efforts of community mobilization and the PMTCT program of antenatal care.

In terms of knowledge with regard to HIV transmission, among community survey respondents, 99 percent of women and men were aware that people can get HIV/AIDS from sexual intercourse without a condom. Ninety-six percent were aware that sharing used needles or instruments is risky. However, the survey also revealed misconceptions regarding HIV infection (see Graph 1). Twenty-nine percent of women and 22 percent of men thought that a person can get HIV through a mosquito bite; 29 percent of women and 17 percent of men believed that using public toilets can transmit HIV; and 19 percent of women and men believed that it could be transmitted by sharing meals with an HIV-positive person. In addition, in terms of HIV prevention knowledge, while 97 percent of women and men agreed that using a condom correctly every time can prevent HIV, 8 percent of those surveyed reported that using traditional medicine is a preventive measure and 10 percent agreed that praying is a strategy to prevent the HIV transmission (see Graph 2).

PLWA Interviews

The interviews with PLWA revealed a misconception about HIV that many respondents saw as prevalent in their communities, particularly among men: there was limited public understanding that one can be both HIV-positive and asymptomatic. For example, as a 33 year-

GRAPH 2: Beliefs Regarding HIV Prevention, Botswana Community Survey



old woman who worked as a counselor with a PLWA youth organization reported:

I've gone public with my status. Some people, when they meet me say I'm lying, the government pays me to say that I'm HIV-positive. They say how can I be HIV-positive if I'm looking so good? They say I want to 'eat government money.'

This misconception reflects a failure in the Government's prevention initiatives to counter the stereotype that anyone HIV-positive would necessarily appear emaciated or ill. It also represents a missed opportunity in public messaging to link testing and treatment programs by targeting for testing those who do not look sick but may have the HIV virus. The latter is something the education component of the Masa program appears to have done successfully for enrollees. As one woman receiving ARVs and good nutrition who rated her health status highly commented, "I look just like anyone else who fears to go for a test."

There was also agreement among interviewees that men's knowledge of HIV prevention and transmission in general was inferior to that of women. One of the male PLWA group leaders interviewed, who worked as a Total Community Mobilization (TCM) field officer, attributed this to both men's lack of information and their denial of their vulnerability to HIV/AIDS:

Men have a problem — they have to be really sick [to test]. There was a man who came for testing but did not go for his results. Now he needs viral loads and CD4 counts. I found him down — I need to persuade him and teach him. Men seem to be ignorant. ... Women have information, they are taught at home by TCM. But men are not at home.

Both HIV-related knowledge and denial based on fear or unwillingness to confront one's own vulnerability to AIDS have direct implications for willingness to test for HIV and experiences with testing.

HIV Testing

While over 80 percent of those surveyed reported access to testing, less than half had tested. When queried about what would assist them to test, treatment availability, couples testing and partner support were cited by the majority. Nineteen percent affirmed that having sufficient food would enable them to test. The majority of those who had tested did so voluntarily, found out the results of their test, reported no breaches of confidentiality or ill treatment and received pre- and

post-test counseling. However, the majority of those tested also felt they could not refuse the test.

For both women and men, television and radio messages were the most common facilitators for testing. Fear of knowing one's HIV-positive status was the most common barrier. Other barriers differed based on sex. PLWA interviews highlighted men's denial of HIV and women's fear of jeopardizing intimate relationships as barriers. When asked to project the consequences of their hypothetical HIV-positive status, the majority of community survey participants expressed fear of being stigmatized in their community, suggesting another significant barrier to testing, also discussed in PLWA interviews.

Half of survey participants had heard of Botswana's routine testing program, an opt-out policy introduced into public health facilities in January, 2004. Fifteen percent of those tested had tested under that program. While the majority favored the policy as explained to them, participants projected both positive and negative outcomes to routine testing. PLWA interviews had similar results, with most of the interviewees' concerns related to the potential for inadequate provision of counseling, necessary to ensure readiness to know one's status, under routine testing.

Community Survey

Prevalence and Characteristic of Having Been Tested for HIV

Eighty-four percent of community survey participants reported that they had access to HIV testing through a VCT or the *Tebelopele* program. Eighty-six percent of women and 78 percent of men agreed that it was possible for someone in their village to get a confidential HIV test.

Six hundred and five community survey participants reported that they had been tested for HIV, constituting 52 percent of the women surveyed and 44 percent of men. Factors associated with having been tested, in multivariate regression analyses adjusted for other respondent characteristics,⁴⁰⁰ included a high school or more education, three or more visits to a medical doctor in the past year, perceived access to good quality medical services and to HIV testing, and inconsistent condom use.

Experiences with Testing

In the community survey, among those tested, 47 percent of women and 63 percent of men were tested at VCT centers, 28 percent of women and 23 percent of men at public hospitals, 7 percent of women and 3 per-

cent of men at NGOs, 7 percent of women (and less than one-half percent of men) at antenatal clinics⁴⁰¹ and the rest in other clinics or private hospitals. Almost all respondents who had been tested reported that it was their decision to get tested (93 percent); however, 62 percent of women and 76 percent of men believed that they could not refuse the HIV test, whether or not they made the decision to test.⁴⁰² The perceived coercive experience of the majority of participants who have been tested raises potential human rights concerns about the voluntary nature of Botswana's testing services.⁴⁰³

At the same time, 98 percent of community survey participants tested reported no ill treatment related to testing and an equal proportion claimed that they did not regret getting tested. Indeed, 92 percent reported that their experience with testing led them to encourage others to be tested. Most participants found out the results of their tests (94 percent) and reported that confidentiality had been strictly maintained at the testing centers (95 percent). Of the participants who had informed their partner of their test (85 percent of those tested), nearly all (99 percent) denied that their partner had physically hurt or threatened them for being tested. Here, as elsewhere in the survey, the incidence of partner violence is likely to be under-reported.⁴⁰⁴ Ninety-six percent reported receiving pre-test counseling and 93 percent of women and 87 percent of men reported post-testing counseling.

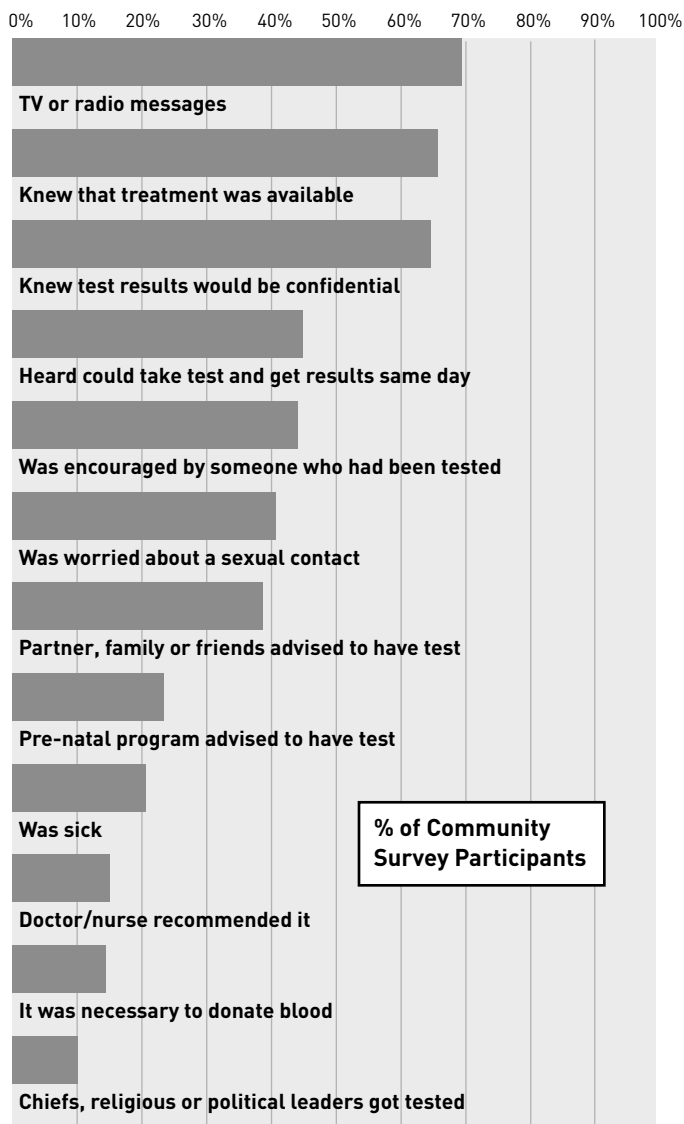
Facilitators of Testing for HIV

The most common facilitating factors reported in the Botswana community survey, for more than three-fifths of those tested, were TV or radio messages, knowing that treatment was available and knowing that the test results would be confidential. Other reasons are listed in Graph 3. Women were significantly more likely to report encouragement from pre-natal programs (31 versus 13 percent) as a facilitator to testing. Men were significantly more likely than women to list treatment availability (74 versus 58 percent), advice from family or friends (44 versus 34 percent), messages from the media (77 versus 63 percent), encouragement or support from someone who had been tested (55 versus 33 percent) and confidentiality of testing (74 versus 56 percent) as factors that influenced them to get tested.

Barriers to Testing for HIV

In the community survey, of the 658 respondents who had not been tested, 48 percent were women and 56 percent were men. In regression analyses, people who

GRAPH 3: Principal Reasons Community Survey Respondents Who Had Been Tested Gave For Being Tested* (n=602)

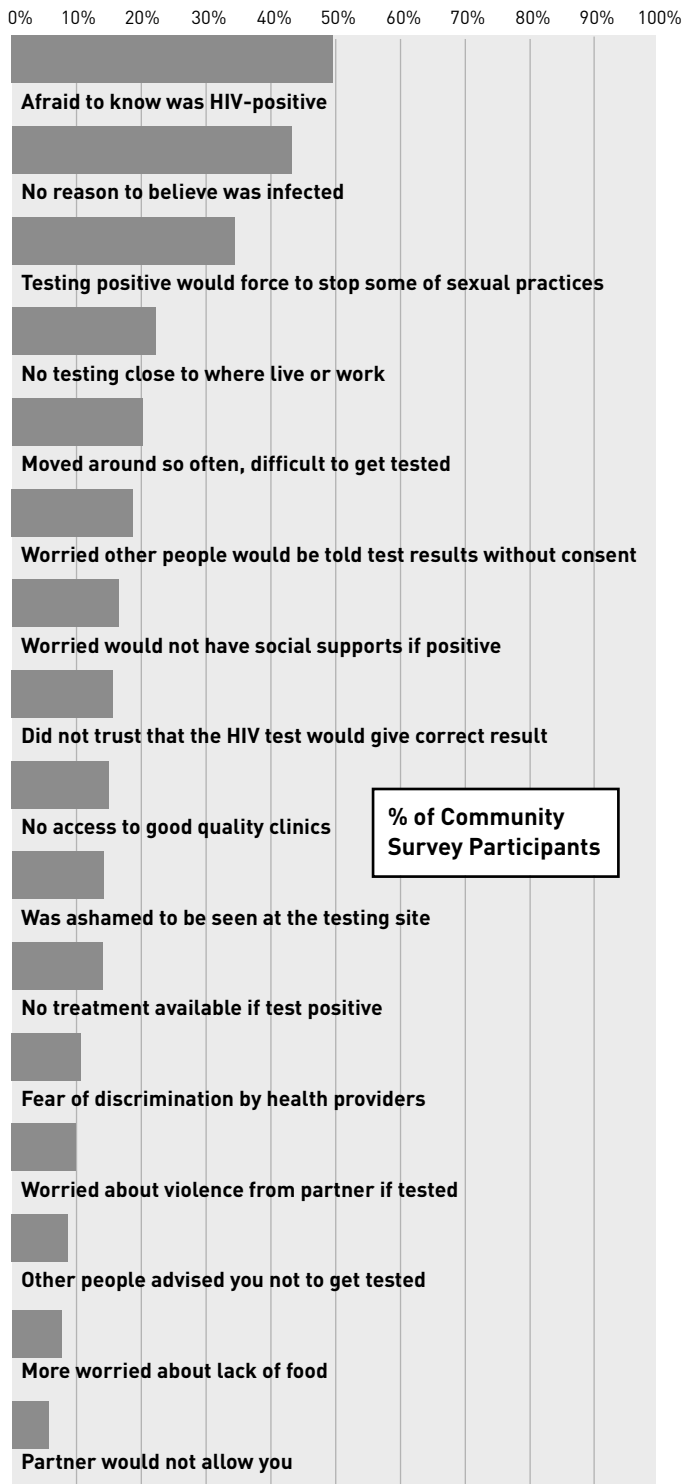


*Respondents could agree with more than one reason.

self-assessed fair or poor health status, who did not know whether ARVs would be available to them if they tested positive or who reported stigmatizing attitudes towards people living with HIV/AIDS were less likely to have been tested for HIV. This suggests that, though only a minority may report being affected by a particular barrier, such as perceived access to treatment,⁴⁰⁵ the impacts on testing behavior can be significant.

The most prevalent barrier to testing reported by those not tested was the fear of knowing one's HIV-positive status. Other reasons agreed to by participants as barriers to testing that they experienced are presented in Graph 4.

GRAPH 4: Principal Reasons Community Survey Respondents Who Had Not Been Tested Gave for Not Being Tested* (n=658)



*Respondents could agree with more than one reason.

All community survey participants were asked questions regarding potential consequences if they were (hypothetically) to test positive for HIV and disclose their status to others. Fear of losing one’s partner if diagnosed with HIV was expressed by both female and male respondents as a serious concern: thirty percent of women and men, both tested and not tested, agreed with the statement that if they were to test positive for HIV and told others, this would result in the break-up of their marriage or intimate relationship.

Fear of being subjected to HIV-related stigma and discrimination may also present a significant barrier to testing. Were they to disclose an HIV-positive status, 28 percent of women and 34 percent of men expected that they would be treated badly at work or school, 40 percent of women and men expected to lose friends, and 50 percent of women and 57 percent of men believed that they would be treated like a social outcast in the community. For those not tested, fears of being stigmatized appear to translate directly into the avoidance of testing: 14 percent said that they were ashamed to be seen at the testing site and believed that going there would cause others to treat them badly.

There were several significant sex differences in the reported barriers to testing. Women were significantly more likely than men to report lack of permission from their spouse or partner (10 versus 3 percent). Men were more likely to cite frequent migration (25 versus 15 percent), not wanting to change sexual practices (39 versus 27 percent) and concerns about lack of social supports if they tested positive (20 versus 12 percent). This points to the need for specific interventions targeted to women and men around improving access to testing and encouraging individuals to test. It suggests that structural issues related to women’s status, gender norms and sexual relationships need to be addressed for these interventions to succeed.

Plans to Test in the Future

Among those who had not been tested, 71 percent reported that they intended to be tested in the next six months. The most commonly cited factors that would enable testing included knowing that they could get treatment for HIV/AIDS (67 percent) and being tested with their spouse or primary sexual partner (64 percent). Other factors that participants agreed would convince them to test were if their spouse or partner would support their decision to test (61 percent) and if there was better counseling at testing sites (60 percent). Nineteen

percent of respondents affirmed that having enough food would remove a barrier to testing. These were no statistically significant differences in facilitating factors for female and male community survey participants.

In regression analyses, respondents who reported unprotected sex had more than twice the odds of planning to test. The only other participant characteristics associated with planning to test were urban residence and self-reported very good or good health. This suggests that, as with those who had been tested, some individuals may be motivated to test based upon a concern about a sexual contact, which may overcome the fear of knowing one's status or unwillingness to change sexual practices upon a positive test result. Respondents with stigmatizing attitudes had less than half the odds of planning to test than those without.

Knowledge of and Attitudes Toward Routine Testing

In January 2004, the Botswana Government introduced HIV testing into health facilities as a part of routine medical care in an effort to increase enrollment in the ARV treatment program by overcoming some of the significant barriers causing individuals to delay testing or avoid it altogether. Survey questions on "routine testing" were based on the best available information at the time describing this opt-out policy.⁴⁰⁶ Given that a minority of the survey sample had direct experience of this type of testing (91 out of 609 individuals reporting testing for HIV), 93 percent of participants were expressing their views of this policy in theory, based on the description provided by field researchers.

For the 15 percent of tested community survey respondents reported having been tested by "routine testing,"⁴⁰⁷ their experiences, as compared with testing at a VCT site, differed in two respects: 6 percent of those tested by routine testing reported poor treatment (from any source) related to testing compared with 2 percent of those tested by VCT; and 93 percent routinely tested received pre-test counseling versus 97 percent for VCT.

In regression analyses, the independent correlates of getting routine testing included being married and seeing a medical doctor more than three times in the past year. The former may imply, as with testing in general, that primary partners and other supportive family members can encourage care seeking, including HIV testing. People who held stigmatizing attitudes towards PLWA were significantly less likely to get routine testing, indicating that it may take more than health

worker-initiation and inclusion of an HIV test into routine medical care to overcome the persistent barrier that HIV stigma presents to testing.

Fifty-four percent of respondents had heard of "routine testing" before the survey. In regression analyses, after adjusting for other characteristics, having heard of routine testing was associated with high school or a higher level of education, household income greater than 1,000 *pula* per month, being married and having more frequent medical visits. Respondents who reported stigmatizing attitudes towards PLWA had lower odds of having heard of routine testing, as did respondents with more fears of being stigmatized if they tested positive, people living in rural areas, people who reported inconsistent condom use over the past year and those with self-reported poor health status. These associations indicate that even with opt-out testing, Botswana faces challenges in reaching the most marginalized populations and those most reluctant to test, including individuals engaging in risk-taking sexual practices.

After an explanation of the policy, a majority of respondents expressed positive views, as shown in Table 2. A majority also agreed with the proposition that this form of opt-out testing may result in less discrimination against HIV-positive people, lead to less violence against women and make it easier for people to get tested and to gain access to ARV treatment. By incorporating HIV testing into regular medical visits, individuals can be tested without requiring them to go to special testing centers which identify them as seeking an HIV test. More women than men expected positive outcomes in terms of decreasing HIV-related discrimination (65 percent of women versus 55 percent of men) and lessening gender-based violence (57 percent of women compared with 52 percent of men).

On the other hand, despite lacking any kind of experience with this testing intervention, survey participants projected some negative outcomes of opt-out testing. Forty-three percent of the community survey respondents believed that opt-out testing could cause people to avoid seeing their health provider for fear of being tested. Fourteen percent of the community survey respondents thought that routine, opt-out testing could lead to more violence against women, given the greater number of women who would be tested and potentially have their HIV-positive status disclosed to a partner. Women's and men's views did not significantly differ statistically.

TABLE 2: Attitudes Toward Routine Testing, Botswana Community Survey*

	n (total N)	Percent
Have ever heard of routine testing	688(1,266)	54
Very much or extremely in favor of routine testing	1,014(1,251)	82
Somewhat in favor of routine testing	105(1,251)	8
Agree that routine testing helps people get access to ARV treatment	1,162(1,250)	93
Agree that routine testing makes it easier for people to get tested	1,120(1,263)	89
Agree that routine testing results in less discrimination (bad treatment) of HIV-positive people	761(1,259)	60
Agree that routine testing leads to <u>less</u> violence against women	685(1,256)	55
Agree that routine testing will cause people to avoid seeing doctor or nurse for fear of being tested	541(1,256)	43
Agree that routine testing leads to <u>more</u> violence against women	174(1,229)	14

*The following explanation was given of the policy of routine testing: "Routine testing is a new approach to HIV testing announced in January 2004. It means that almost everyone who visits a health clinic or hospital will get a number of tests, including an HIV test, unless they say no to it."

PLWA Interviews

In interviews with PLWA, barriers to testing had a particular gender cast. ARVs were singled out as a significant facilitator to testing. Opt-out testing was viewed favorably, in large part due to its projected positive impact on overcoming the fears of knowing one's HIV status to be positive and of being stigmatized for testing.

Barriers to Testing

Men's Denial of HIV

Participants in the qualitative interviews described a cultural norm that sanctions multiple sexual partners for men and a climate of denial that fosters unsafe sexual behavior. A 32 year-old woman who tested positive together with her husband explained how men relied on myths and excuses to avoid taking responsibility for preventing HIV by seeking their status.

For men, HIV/AIDS is not real. They would rather say they were bewitched. That, 'I am sick because that woman wants me to die to take my property.' Men want to stay strong, to be perceived as strong, and HIV/AIDS and strength do not go together.

Interviewees, both men and women, noted that men were much less willing than women to acknowledge the existence of HIV/AIDS and its impacts. Thus they were less willing to engage in prevention and care ini-

tiatives, including testing, or to go for a test unless they were very sick — "Men think HIV/AIDS is not for them, only for women."

One man interviewed, now a support group counselor, learned of his status after he tested in 1999 when his girlfriend died of AIDS, but did not believe his results because he was asymptomatic. In 2002 he was sick and tested again and this time accepted his HIV-positive status.

Most women go for testing, most men do not. Men have a block in their minds — I don't know what they think. Their minds are closed. In our support group women lead men. They are the ones that encourage men to test.

Another man, a community educator agreed.

Women — more come for testing. I refer four women for testing in a week, twenty in a month and two men in a month.

One woman, who had herself been fearful to test until friends encouraged her to seek the cause of her illness, described the perspective from the other side of a partnership:

Men fear finding out. They hear from their woman [her HIV-positive status] and then they know [their own status]. Then sometimes they go for a

test. I told my boyfriend. That made for a difficult relationship. We don't see each other very much any more. He has not had a test and he doesn't want to go for one.

One of those interviewed, a youth educator, believed that the key was how the message to test was communicated:

We go out to reach men ... to teach them about HIV/AIDS, OIs [opportunistic infections] and STDs. They open up when they talk to women. We go one month at a time, and for follow up. ... The DEB-SWANA [gold mine] men did get tested. They took our advice. ... CEYOHO [a youth HIV/AIDS support group] needs to target men, to go to the head boys of the cattle posts. ... I think it's only how you talk to them. That's when you can help them change their mind.

Men's denial of their own potentially positive HIV status also translated into their abandonment of HIV-positive female partners, whether out of ongoing denial, rejection or blame of the woman for alleged infidelity, HIV-related stigma or fear of being stigmatized.

Women's Fear of Jeopardizing Primary Relationships

In terms of barriers to testing, interviewees suggested that many women feared that testing itself (regardless of the outcome of the test) would jeopardize their primary relationship. As one young woman living near Gaborone explained in an interview:

[Women's] partners do not allow them to go for testing. Abuse by partners is a problem. Men run away from women sometimes just for testing, whether they are HIV-positive or HIV-negative.

Another young woman voiced the same concerns: "At PMTCT women don't want to test because they are fearful of men leaving them behind."

Other qualitative interview respondents reported that, although women tested more frequently and earlier than men, the primary barrier prohibiting many women from testing was the fear of losing their partner upon disclosure, which would translate into a loss of financial support and imminent or worsening poverty and suffering. Men were perceived, and in most circumstances in fact were, the financial mainstay in domestic relationships. As one 22 year-old woman who believed she became infected with HIV from her boyfriend recounted:

Women don't want to be tested because of stress, stigma and discrimination. Women are also afraid to lose their partners. When women tell their partners they are HIV-positive, the men run away. This happened to me. My partner left. My partner initially encouraged me to get tested when he saw I was sick. He refused to get tested himself.

Men were also fearful of abandonment by partners, but their fears, as one 31 year-old woman expressed, were possibly centered on a loss of status or societal respect due to the stigma associated with HIV/AIDS:

Men are also afraid to lose their partners. They are ashamed to be seen at the testing site. They think that people will discriminate against them. They think they will be valued less than people who are not HIV-positive.

Self-Stigma and Fear of HIV-Related Stigma

As is clear from the testimony quoted above, interview participants mentioned stigma and discrimination as a barrier to testing. In the case of women, stigma could be two-fold, characterized both by prejudice against PLWA and belief in gender norms for women of virginity and monogamy. One 31 year-old single woman suggested:

Women are ... afraid of stigma and discrimination. They are afraid that people will assume they had many sexual partners.

Several individuals interviewed gave men's "shame," a combination of self-stigmatization and fear of stigma and rejection, as a reason for avoiding testing. For example, one 30 year-old woman who took eight months to come to terms with her diagnosis said: "Men are scared of knowing their status. They think people will laugh at them. They would be ashamed."

PLWA interview participants also spoke of how the nature of VCT may have contributed to fears of being stigmatized for visiting the special testing site. At some health clinics, caravans (mobile van facilities) were placed externally to the main building and used as HIV testing facilities. Interviewees noted that, because it stood alone, and was exclusively used for purposes related to HIV, this type of testing facility discouraged people from taking a test by contributing to the differential medical treatment of HIV/AIDS. As a woman who had sought out testing at a hospital on her own in 1994 after TB treatment failed, explained:

Nurses say that a person should go the caravan [to be tested]. They don't go. They should get the test and counseling in the observation room [of the clinic]. The caravan is a barrier for women and men.

Facilitators to Testing

The qualitative interview respondents cited the availability of ARV therapy — and thus mitigation of the fear and/or the reality of imminent death — as a key facilitator for many, encouraging the taking of an HIV test. One 37 year-old man explained:

The reason I had no problem accepting my status was because there were ARVs available. I had no issues with testing. I knew that to be HIV-positive was not a death threat.

He had been tested after his pregnant, live-in partner tested positive for HIV and had suspected his own positive status “all along.”

Similarly, another person living with HIV/AIDS, speaking of herself and her husband, declared: “We were motivated [to test] by the fact that we could get therapy.”

One woman who had been tested in 1994, and did not initially go back for her results, spoke of the importance of the availability of same-day test results as a facilitator to testing: “There is much more testing now because you get your results in one day, and not in three months the way it used to be.”

Routine Testing

The interviews with PLWA revealed strong support for the idea of routine, opt-out testing as it was defined by PHR researchers. The main reasons for support of the policy were that it would facilitate more people getting tested, because it would take away some of the shame of asking for a test or going to a free-standing center and, moreover, would result in decreased stigma by treating HIV/AIDS like any other illness. A 34 year-old woman tested without her consent when pregnant explained:

I support the new policy. More people will get to know their status. Going from Gabane to Gaborone for an HIV test alone is a big deal. It is difficult. It's better that it be included in a group of issues for a health check. And there is less fear when the nurse asks you for a test, rather than you ask her.

A 39 year-old man who tested at a VCT site when he became ill had heard about the new program of routine testing but did not understand it. After an explanation and further discussion he voiced his support:

Originally nurses sent people to clinic caravans to be tested and they just went home. Routine testing is better. More people will get tested. If many people know their HIV status, then HIV will be taken as any other disease.

Other interviewees mentioned a number of caveats to their support of opt-out testing. Most concerned the need to guarantee pre- and post-test counseling to help prepare people for receiving the results. One man from Serowe feared the consequences of not having counseling:

I think counseling before and after the test is necessary. There would be problems if there was no counseling. Some people can kill themselves. I know that some people kill themselves when they learn the result.

One woman, echoing those quoted above, described how previous government programs had tested people without this foundation:

Opt-out testing is good but the government would need to implement more manpower. You need counseling along with routine testing. You've got to be ready to take an HIV test. The 'Show You Care Campaign' has some problems. People go for the t-shirt and the tickets [to a local sporting event] only, not for the HIV testing results. And then they have to deal with the test results after.

This caveat seems especially salient for individuals like the participants in the community survey, for whom, among those not tested, the main reason for not testing was fear of knowing one's positive status. Moreover, those tested by opt-out testing in the community survey less frequently reported having received pre-test counseling than those tested under VCT.

HIV-Related Stigma and Discrimination

Fear of knowing one's HIV-positive status was in part rooted in the fear of being stigmatized and discriminated against if that status is suspected or disclosed. Over half of community survey participants held stigmatizing or discriminatory views. At the same time, nearly all projected acceptance of an HIV-positive family member and support for HIV-positive (but asymptomatic) teachers and students. Fear of being stigmatized or mistreated was a concern of many community survey participants, as indicated by the finding that over half believed they would be treated as a social

outcast in their communities if they were known to be HIV-positive. Men had a higher level of projected fears of stigma than women. The majority of community survey participants reported that discrimination had lessened in Botswana with the advent of treatment. PLWA interviewed agreed that HIV-positive status was more accepted and easier to disclose than in the past and most had disclosed their status to some family members. Many, however, reported experiences of stigma and discrimination at home, work or in the community. Both female and male PLWA agreed that social stigma and poor treatment were worse for HIV-positive women than for men. They cited gender norms and discriminatory attitudes that blame and devalue women as reasons for this.

Community Survey

Stigmatizing and Discriminatory Attitudes

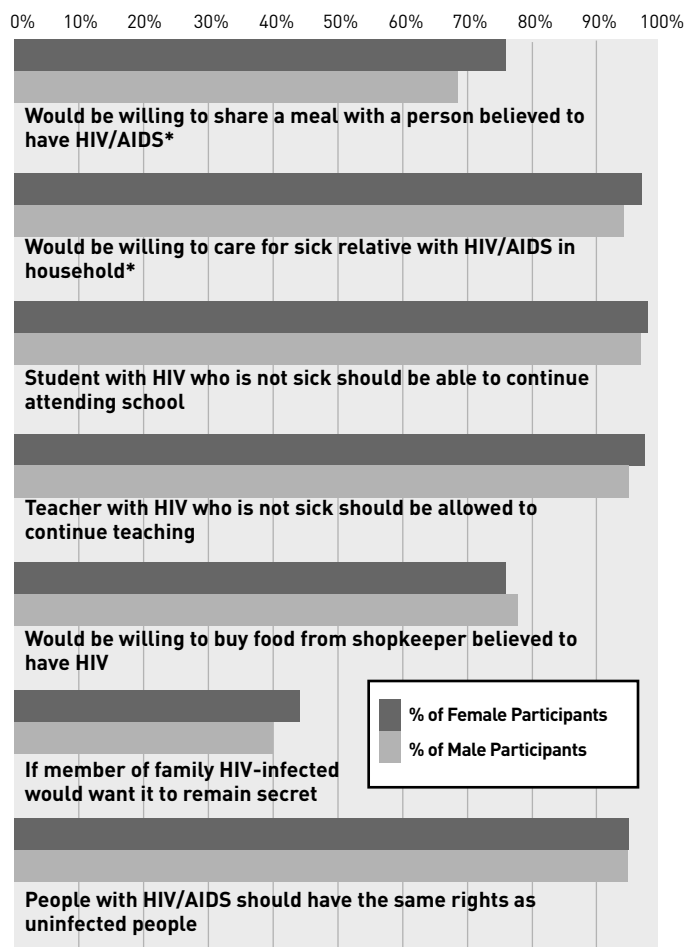
Fifty-four percent of women and 51 percent of men reported at least one stigmatizing or discriminatory attitude towards PLWA.⁴⁰⁸ Stigmatizing or discriminatory attitudes are shown in Graph 5. Certain attitudes may reflect lack of knowledge regarding transmission of HIV. For example, 23 percent of women and 32 percent of men said they would be unwilling to share a meal with someone they believed to be living with HIV or AIDS and 23 percent of women and men would not buy food from a shopkeeper or food seller they believed to have the AIDS virus.

At the same time, there was clear support for the rights of PLWA among those surveyed. Ninety-seven percent of women and men believed that HIV-positive students “who are not sick” should be allowed to attend school and if a teacher has HIV “but is not sick,” that they should be allowed to continue teaching. Sixty-nine percent of women and 58 percent of men thought that there was less discrimination in Botswana since the advent of ARV treatment.

While those surveyed affirmed nearly universally that they would accept a sick family member, the fear of being stigmatized by others was concurrently expressed by more than two-fifths of women and men. Specifically, 97 percent of women and 94 percent of men said they would be willing to care for a relative with HIV/AIDS in their household, but 42 percent of women and men would want it to remain a secret if a member of their family became ill.

Participants in the community survey were also asked to project how they would react to a spouse or

GRAPH 5: Attitudes toward PLWA, Botswana Community Survey (n=1258)



* Statistically significant differences between responses of women and men.

partner testing positive for HIV.⁴⁰⁹ Ninety-seven percent of women and men reported they would get a test immediately, 94 percent would be grateful that their spouse or partner had disclosed their HIV-positive status and 90 percent would always use condoms if they remained with him or her. However, 62 percent of women and men said that they would assume that their spouse or partner was having sex with someone else, 8 percent said they would kick the spouse or partner out of the home and 5 percent admitted that they might try to hit or hurt the spouse or partner. There were no statistically significant differences between the responses of women and men.

Fears of Stigma and Discrimination

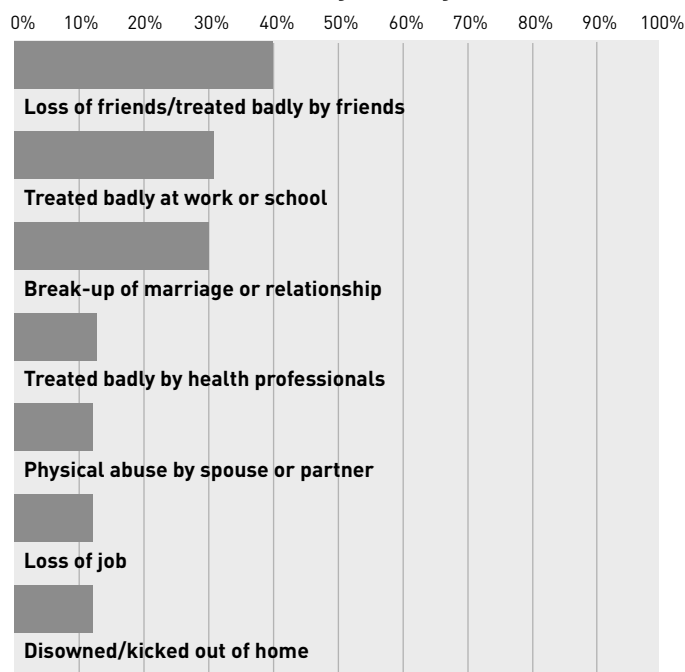
Despite their own reported support for the rights of PLWA, and projected acceptance of family members with HIV, the community survey results demonstrate the per-

sistence of the fear of being stigmatized and discriminated against associated with testing positive for HIV and disclosing one's status. These results are shown in Graph 6. Fifty percent of women and 57 percent of men believed that their community would treat them like a social outcast were they known to be HIV-positive. Forty percent of women and men feared a loss of friends. Thirty percent of women and men believed that disclosure of their HIV-positive status would lead to the break up of their marriage or relationship⁴¹⁰ and 12 percent of women and men feared resulting physical abuse by a spouse or partner. As many as a quarter to a third of those surveyed also expected discrimination as a consequence of HIV-positive status: 28 percent of women and 34 percent of men believed that testing positive and disclosure would lead to bad treatment at work or school; 10 percent of women and 14 percent of men feared a resultant loss of a job. Likewise, 10 percent of women and 14 percent of men expected poor treatment by health professionals. Overall, men exhibited a higher level of projected fears than women should they test positive.⁴¹¹

PLWA Interviews

PLWA interviewed reported an improved climate for PLWA in Botswana. Nevertheless, many described experiences of HIV-related stigma and discrimination. Both women and men expressed the view that the situ-

GRAPH 6: Projected Consequences of Disclosure of Hypothetical HIV-Positive Status in Botswana Community Survey (n=1244)



ation was worse for HIV-positive women than for men, a phenomenon rooted in the lack of women's rights and women's low status in Botswana.

Perceived Decreased Prevalence of Stigma and Discrimination

Interview participants believed that stigma and discrimination had lessened over time in Botswana. One man, who found out his status in 2003 and had very supportive parents who volunteered for the home-based care program and support groups, said:

There is discrimination that comes from telling your status but not much. Not like in the past. Some are now living with people who have HIV/AIDS, which makes it easier.

A 33 year-old woman who tried three times to go to Tebelopele before she managed to take a test, because she was afraid of what people would think, described how one of her sisters needed time to believe her and become supportive.

It took a while for people to accept my status. My friends were becoming few. I had five and I was down to one. People who used to invite me out didn't anymore. Now every weekend, I'm out!

The lessening of HIV-related prejudice and unequal treatment was particularly evident in interactions with health care workers. One woman described the situation at the time she found she had HIV, a decade ago.

In 1994 there was discrimination from health workers. They said things like, 'Don't come near me. Don't touch me. You are HIV-positive.' Some people would go to a nurse at the clinic worrying about HIV. The nurse would say, 'Ah, who told you this is HIV/AIDS. Just go home.' Stigma and discrimination is less now. It's gone down, especially in health clinics.

Another woman receiving treatment at the ARV treatment clinic at Sekgoma Memorial Hospital in Serowe explained:

Nurses are also trained for counseling, they smile to patients, not like those from the olden days.

The reportedly decreasing stigma and discrimination was credited to the availability of ARVs. One woman, who found out her HIV status when she became ill and had started ARV treatment a month before the interview, described how she and her family could more easily come to terms with her diagnosis.

I told my elder sister and my mother. They accepted my status. They were upset to start but felt better about it when they knew that you can get well if you take the treatment.

Positive Consequences of Disclosure

Twenty out of 24 PLWA interviewed chose to share their HIV status with some family members. Moreover, interviewees spoke about their increased level of comfort with disclosure and their motivation to speak openly about living with HIV/AIDS to family, friends, members of the community and wider audiences.

I talk to my family, 'Here is the situation. If you listen to me, you can live like me.' I want them to live positively.

Yes, I advise my neighbors, family and friends to get tested. I say, 'Do you remember how I was? Don't let this happen to you.'

When I tell people my status, there is change. I think my voice comes to their ears. If people treat me badly, I don't accept it. No one treats me badly now.

PLWA interviewed reported that their communications frequently resulted in the behavior change of others, primarily evidenced through family members, friends and others taking an HIV test. As one woman, put it, "After I talk to people they go [for testing]. I really know how to convince someone. People understand now." Another reported, "All of my [3] sisters got tested because I took a test."

At the same time, respondents reported evidence of stigma and episodes of discrimination when their status was known in their families, the workplace and the community, and how persistent negative attributions to PLWA and HIV/AIDS contributed to their sense of shame and alienation in these contexts.

Negative Consequences for PLWA Within the Family

In the home, interview participants noted that stigma was evident in how family members sought to segregate cooking and eating utensils. Often the relative with HIV or AIDS was forced to eat meals alone. One young woman, who got HIV from her partner of two years, described how she tried to keep her HIV-positive status hidden from her family to avoid poor treatment.

There was a big problem within the family. They don't want to share meals with me or utensils with me. They think I am dying. They discovered my status because I was given a blanket by President Mogae. He was giving blankets to people who were HIV-positive and I was one of them. My family discovered it then and started treating me badly then.

At the Workplace

Both fear and the actual presence of discrimination in the workplace prevented people from disclosing their status, or even learning of it. One woman, who had not herself experienced much discrimination — which she ascribed to not being sick — commented:

Stigma in the workplace is still a big issue. ...people think they will lose their job [if it is found out that they are HIV-positive]. You have many issues to handle and numerous visits to the clinic are necessary. This needs to be okay with the employer.

In the Community

Stigma in the community was reported as mainly expressed by gossiping and shaming behavior where individuals suspected of having HIV were singled out and publicly disparaged for their status. Or community members refused to have physical contact with them, for example, to sit together on the bus. A 26 year-old woman whose current boyfriend is also HIV-positive and very supportive, gave this example:

Women go to the boys and say, 'that lady will infect you because she's HIV-positive'. That person [one of the boys] will come back and tell me.

Fear of Stigma Discouraging Access to Treatment

Taking treatment could "out" someone's status before they were ready to disclose it, which they might hesitate to do, fearing the rejection of others. One 37 year-old woman, though active in TCM, head of a support group, possessing a diploma in counseling and currently studying to be an HIV/AIDS educator, had not been able to discuss her illness with her family even though her niece and brother had died of AIDS and she herself had been gravely ill prior to treatment.

They had a meeting under the tree and said, 'we should save money for her casket.' ...Even me, I didn't tell. But if it's time for my medicine my girl [daughter] will just bring my bag to me. But I didn't say anything. She just knows.

One leader and educator similarly described the effects of stigmatizing attitudes on treatment.

Lots of people come here [to the treatment center], take ARVs and hide them. When it's time to take them, they go into the toilet. They hide from their families and communities.

Gender Dimensions of HIV-Related Stigma and Discrimination

Both female and male interviewees noted that women with HIV or AIDS generally experienced more stigma and discrimination than men. HIV-related social consequences for women appeared to be inevitably entangled with expected norms of behavior, gender stereotypes, male power and discriminatory attitudes towards women. One 28 year-old man reported:

There is more stigma for women who are HIV positive. Some women are sex workers; people think if you have HIV, you are a prostitute. Yet less than five percent of women are prostitutes or are having sex to get money.

Given many women's dependence on men for legal status and economic security, the fear of HIV-related abandonment was understandably a great motivation toward non-disclosure. As a 33 year-old woman explained:

I think there is more stigma against women than men. Men stigmatize women. When men find out that their partner is HIV-positive they say, 'No, I'm going to look for the people who are not HIV [-positive].' That's why women stay quiet when they come back home HIV-positive.

One reason suggested by those interviewed for this greater stigmatization was the perception that more women disclose their status than men and were thus relatively more exposed to the consequences. One young woman, who described herself as very open with her status, explained:

Most women open up with their status. Most men don't disclose and therefore women get the stigma.

Several people noted — and the gender-breakdown of the membership of the support groups participating in the interviews themselves underline — that women participated more in PLWA support groups and other volunteer work. One man, himself very active, nonetheless was stymied by this, and ascribed it to fear of stigma:

This is a thing which embarrasses me a lot. How can we pull men into support groups? ... They don't want to be seen talking about HIV/AIDS.

Others placed women's disclosure and men's non-disclosure in the context of the traditional gender-based roles and community care responsibilities shouldered by women without recognition or compensation. As one female volunteer put it:

Most [of those in a small village support group] are women, also some are men. Men always think that women like to volunteer; [men say], 'why should I go there if I am not paid?'

In the context of social, economic and legal gender discrimination in Botswana, the situation of women's inequality was so endemic that several of the women interviewed were at a loss to put it this disparity into words, resigned to greater stigma and discrimination for female PLWA as just the way things were, women were inexplicably treated more poorly and viewed as inferior to men.

Men discriminate against women who are HIV-positive. Women don't discriminate against men. I don't know why.

...women are valued less than men in society. I don't know why. It is not something that I can have the words to explain.

One woman, infected by a partner who refused to use condoms because he said that they diminished sexual pleasure, saw direct links between household and national decision makers.

Women are valued less in our society. Men are the only ones making the decisions. The leaders in our country are all men.

In order to diminish HIV-related stigma and discrimination in Botswana, the lack of women's autonomy must be acknowledged and addressed. Discriminatory norms and realities are particularly salient in the context of heterosexual sexual relationships, the source of most HIV infection in Botswana.

Sexual Practices: Risk-Taking and Risky Circumstances

The community survey results describe the commonality of sexual risk-taking among participants, who reported multiple sexual partnerships and engaging in unprotected sexual intercourse. Women's lack of control over the deci-

sion whether to have sex or use a condom was at the root of risk for many women. This lack of control is the result of socially-sanctioned, economically-driven and culturally embedded behaviors and circumstances. The line between choice and compulsion regarding sexual practices can be stark or subtle for many women, particularly for those, like many in the study population, who may have low incomes and lack access to resources such as food for themselves or their children. These findings were confirmed and amplified in interviews with PLWA.

Community Survey

Eighty-nine percent of community survey participants had ever had sexual intercourse. There was no statistically significant difference between the responses of women and men in the survey sample.

Multiple Sexual Partnerships

Multiple sexual partners were reported by 25 percent of women and 40 percent of men in the community survey. Results are depicted in Chart 1. Of those who had ever had sex, 8 percent of women and less than 5 percent of men reported not having a sexual partner in the past year. Of those who were sexually active,⁴¹² 13 percent of women and 19 percent of men reported more than one partner in the past month. Of those who were not sexually active, 71 percent of women and 60 percent of men said that they practiced abstinence as a

way to prevent themselves or others from becoming infected with HIV.

Condom Use

In terms of unprotected sex, 46 percent of sexually active community survey participants reported having had sexual intercourse without a condom over the past year — for a variety of reasons — and 11 percent had

CHART 1: Number of Sexual Partners in Past 12 Months, Botswana Community Survey (n=1122)

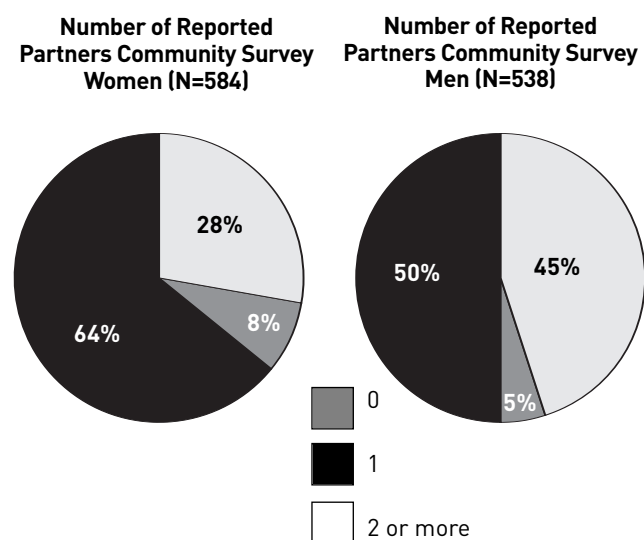


TABLE 3: Reasons for Unprotected Sex in the Past 12 Months, Botswana Community Survey*

Statement of Reason	Percent of participants who agreed				p-value
	Women		Men		
	N	n(%)	N	n(%)	
Your spouse/partner does not want to	251	134(53)	221	29(13)	0.000
It decreases sexual pleasure	252	116(46)	222	154(69)	0.000
You or your spouse/partner(s) are trying to get pregnant	252	76(32)	222	78(32)	0.248
You use other birth control methods	252	74(29)	223	80(36)	0.130
You have no control over whether your spouse/partner(s) uses a condom	250	55(22)	222	16(7)	0.000
Condoms are inconvenient to use	250	38(15)	223	65(29)	0.000
Condoms do not prevent HIV/AIDS	251	15(6)	221	11(5)	0.635
You cannot afford condoms	252	13(5)	223	9(4)	0.561
Condoms are not available in your area	251	12(5)	223	13(6)	0.610
You do not know how to use a condom	252	7(<3)	222	6(<3)	0.960

*Respondents could agree with more than one statement.

unprotected sex with a non-primary partner during that same period.⁴¹³ There were no significant differences in condom use data between men and women.

Table 3 presents the reasons given by survey participants for not using a condom with each sexual encounter over the past year. Fifty-three percent of women, as compared with 13 percent of men, reported not having used a condom in the past year in at least one instance because their partner refused. Twenty-two percent of women, versus 7 percent of men, agreed that they had no control over whether their partner used a condom or not. This highlights that condom use is a decision that more typically rests with men in Botswana, as would be expected given patriarchal norms of sexuality and power dynamics in intimate partner relationships.

Women's Lack of Control Over Decision Making in Sexual Relationships

The lack of control experienced by women with regard to condom usage was borne out in other responses to the community survey. Of those sexually active, thirty percent of women and less than 2 percent of men reported that their partner alone made the decision when to have sex. Five percent of women and 31 percent of men agreed that they alone made that decision.

In analyses adjusted for other participant characteristics, lacking control in sexual relationships was associated with risky sexual practices.⁴¹⁴ For example, women in the community survey who reported having little decision making power over engagement in sex had three times the odds of exchanging sex for money or other resources⁴¹⁵ and nearly two times the odds of having multiple partners⁴¹⁶ as others surveyed.

PLWA Interviews

The interviews with PLWA provided some illumination as to potential reasons for engaging in sexual risk-taking practices, such as having multiple sexual partners and failing to use condoms consistently. Participants reported women's lack of control in sexual relationships and discussed changes to their own practices after learning of their HIV-positive status. While several interviewees, female and male, had reduced their number of partners and increased condom use, lack of autonomy in their primary relationships prevented some women from protecting themselves and others, despite knowing their status.

Multiple Sexual Partners

The commonality of men having multiple sexual partners in a highly mobile society was described by one PLWA counselor:

Some women say, 'My husband got those small houses over there [residences where the husband has relationships with other women]. Maybe he has five small houses — one in Jwaneng, Francistown, cattlepost and more.

Another woman who also worked as a counselor described the reason for men having multiple sexual partners in terms of the formation of masculine identity.

Because for a man to be a man, he has to be seen around with girls. There is a lot of peer pressure on guys. They have to prove they are men.

Sex Without Condoms

Qualitative interview respondents spoke of the realities of multiple sexual partnerships and the barriers to condom usage. Speaking from his own experience, one man explained:

Men are closed. They are stuck in their ways and this puts them at risk. They don't want to change their sexual behavior and their habits. This is the problem. ... Before I became infected, I was one of those men. My mind was closed, I did not use condoms. I convinced women not to use condoms.

Other interviewees also discussed the refusal of men to use condoms, and a willingness to believe the myths and misconceptions concerning their use. The same man described this as well:

Condoms are a problem. There is a saying in Botswana that you can't eat seeds with plastic. This means that sex with condoms does not feel as good. Men also say that when they use condoms, they become sick.

One of the young women interviewed agreed and described how men persuade women to have unprotected sex:

Men have the wrong information about condoms also. They think it is not 100 percent safe. They tell you there are worms in condoms. They say it is safer to have sex without a condom. They say condoms have HIV in it. They also say condoms reduce sexual pleasure.

She was infected by her partner after they stopped using condoms in order to get pregnant. She also commented, "I don't know a lot about condoms. Some say it is 100% safe, others say it is not. Now we use condoms."

Women's Lack of Control

Women's lack of control over when to have sex and whether or not to use condoms was evident in the interviews. One woman described how she became infected from sexual intercourse with her husband.

I trusted my husband; he did not know his status. My husband had other partners. He refused to use a condom. I could not say no. We fought because I said no to sex without a condom. He abused me physically because of this, and afterwards I was afraid to say no.

Her husband had accused her of having other partners and threw her out of the house after she tested positive for HIV, but reconciled with her four months later. He later tested positive for HIV.

Another woman described women's lack of control over childbearing:

I have a friend, a woman who is HIV-positive and she had two kids [by] her husband because he says so. She says, 'I have to obey this man.'

Another described her own economic dependence on her sexual partner:

I was given things in exchange for sex. I had trouble saying no to sex because he was supporting me. This was difficult. After he gave me money, I felt I had to have sex.

One male support group counselor described the negative impacts of the social sanctioning of intergenerational relationships that leave young women, like the previous interviewee, vulnerable to more powerful, better-resourced partners.

If I am a man and have cars and money, and I see schoolgirls, I would say to them, 'come have sexual intercourse and I will give you money.' This contributes to HIV. The man will then refuse to use a condom. These are the men who spread HIV.

Behaviors and sexual practices that place women and men at risk of HIV arose out of gender roles and norms woven into the fabric of Botswana society. This construct of gender, maintained by laws, social practices and cultural values, persistently disenfranchised and endangered women.

Sexual Behavior Change Among PLWA and Barriers to Change for Women

Sexual behavior change could result from an HIV diagnosis. Interviewees reported having fewer sexual partners and using condoms more consistently.

Yes, my sexual behavior has changed. I now use condoms every time I have sex, and my husband has agreed.

Before, I was active. Now I cool it. I have a reduction in the number of partners and I use a condom.

Now I have only one partner. My dreams tell me that I am going to marry her. I have been only with her. Before, I had many partners, more than ten a month. I did not use condoms then. Now I have only one partner and I use condoms all the time.

Those interviewed noted the emotional and psychological complexities of changing a fundamental aspect of one's life. One woman, who had decreased her partners to two, commented:

I think two partners are OK. It is better to have two partners. If I have only one, I will put too much trust in him. Too much heart in one person is dangerous.

Women who reported no change in their practices when they discovered their HIV status reported that they lacked control over sexual decision making. One 22 year-old woman, nine months pregnant, explained that she had reduced her number of partners but not changed her patterns of condom use, because "If he refuses, I have no say." She suspected that her partner had tested for HIV, but hadn't told her so.

Gender Norms and Beliefs and Perceived Vulnerability to HIV/AIDS

Findings from the study demonstrated the prevalence of gender discriminatory beliefs among a significant minority of the study sample. For example, 17 percent agreed that a man may beat his partner if he believes she is having sex with other men. Ten percent affirmed that it is a wife's duty to have sex with her husband even if she does not want to.

This is of particular concern when the relationship of these beliefs to sexual practices is considered: regression analyses demonstrated that holding gender discriminatory attitudes is predictive of sexual risk-taking and risky sexual circumstances. In other words, participants who affirmed women's lesser legal and social status and subservience to men had greater odds than those who did not of engaging in multiple sexual partnerships or unprotected sex, or lacking control over decision making in sexual relationships — circumstances that increase the risk of transmission of HIV.

Factors identified as important to creating vulnerability to HIV for women and men by PLWA interviewed reflected the inequality and disadvantages faced by women and the control over decision making possessed by men. PLWA experiences elaborated on these views and confirmed that, whether gender discriminatory beliefs are held by women or men, the legal, social, economic and cultural norms that they reflected often had devastating consequences.

Community Survey

Prevalence of Gender Discriminatory Beliefs

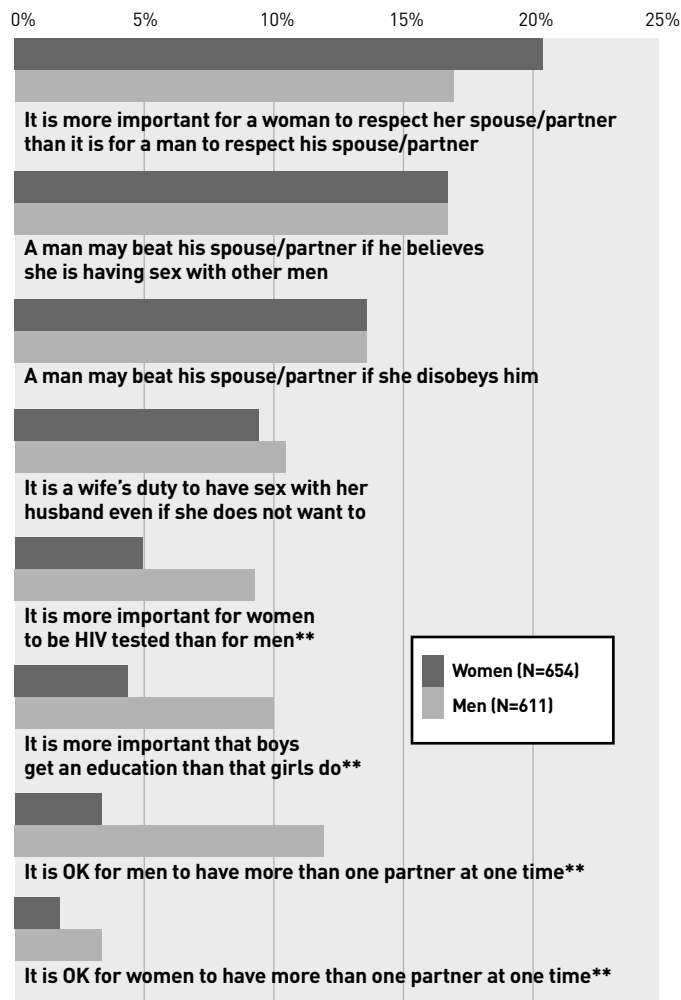
Overall, the large majority of those surveyed held at least one belief that could be described as gender discriminatory. In the community survey sample, women held slightly more gender discriminatory beliefs than men: 5 percent of women and 10 percent of men reported no discriminatory beliefs; 68 percent of women and 65 percent of men reported one to two; and 26 percent of women and 25 percent of men reported three or more.⁴¹⁷

In terms of specific beliefs, each belief was held by a significant minority of those surveyed. Where there were differences between responses of women and men in the community sample they were quite small or statistically insignificant, as shown in Graph 7.

Study participants endorsed attitudes that women should be subservient in their relationships with men. Nineteen percent of all community survey respondents agreed with the statement that it is more important for a woman to respect her spouse or partner than it is for a man to respect his spouse or partner. Ten percent of all survey respondents agreed that it is a wife's duty to have sex with her husband even if she does not want to. Seventeen percent of all participants agreed that it is acceptable for a man to beat his partner if she is having sex with other men and 13 percent agreed that it was acceptable for him to beat her if she disobeys him.

In terms of expectations of sexual behavior, women's and men's attitudes as reported in the community survey diverged primarily and to the greatest degree over the approval of concurrent multiple sexual partnerships. Whereas 3 percent of women and 12 percent of men agreed that "it is OK for men to have more than one partner at a time," 3 percent of men affirmed this behavior for women (versus 2 percent of women surveyed), suggesting that, for male respondents, different standards of behavior apply based on sex. This may constitute under-reporting of this belief, indicating the social undesirability of sanctioning engagement in potential sexual

GRAPH 7: Specific Gender-Discriminatory Beliefs, Botswana Community Survey



*This is a gender discriminatory belief because it assumes that women are more responsible for the transmission of HIV than men are, or that mother-to-child transmission is largely responsible for the AIDS epidemic.

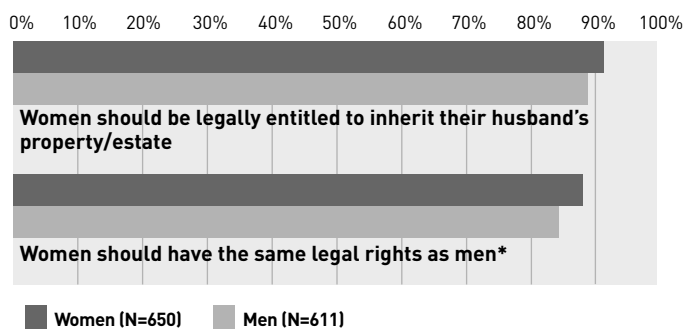
**The difference between the proportions of men and women holding this belief is statistically significant.

risk-taking in the context of a high level of community knowledge of the transmission of HIV through unprotected sexual intercourse and public awareness of the elevated prevalence of HIV in the national population.

Prevalence of Beliefs in Women's Rights

As shown in Graph 8, more than four-fifths of community survey participants reported believing in equal rights for women in the legal sphere. This points to a divergence between participants' attitudes and the legal system in Botswana, which does not grant the same rights to women as to men under either civil or

GRAPH 8: Individual Beliefs in Women's Rights, Botswana Community Survey



* The difference between the proportions of men and women holding this belief is statistically significant.

customary law, and suggests an opportunity for crucial legal reform with popular support.

Gender Discriminatory Beliefs Predict Sexual Risk

Community survey participants who held three or more gender discriminatory beliefs had 2.7 times the odds of having unprotected sex in the past year with a non-primary partner as those who held fewer discriminatory beliefs.⁴¹⁸ Men who held three or more of these beliefs had 3.6 times the odds of having had sex without a condom with a non-primary partner in the same period.⁴¹⁹ Other associations with specific beliefs are shown in Table 4.

PLWA Interviews

In interviews, PLWA highlighted women's dependency on male partners as the most significant reason mak-

ing them more vulnerable than men to HIV transmission. Testimony also revealed that women's lesser status in Botswana fostered ongoing harm to women even after they become infected, and moreover, increased the precariousness of their ability to meet basic needs. Participants also discussed the role of gender norms around fertility as encouraging risk-taking behavior for both women and men.

Women's Vulnerability to HIV

The 24 respondents spoke about gender inequality. Many expressed women's fear of losing the male family breadwinner and of the poverty and consequent life-threatening circumstances that were associated with this loss in a country where women faced many legal and social barriers to economic opportunities and self support. One woman assisting others to form support groups explained:

In Shashe-Mooke, 5 kilometers from Francistown, there's a care center and active people in a support group there, and the epidemic there is big. Because of poverty. ... They are starving. Women are heading households, there are so many. ... Most are not working.

This economic dependence translated into a lack of power in negotiating sexual relations, often resulting in sex without condoms, in order to keep a partner providing financial means, or to enable a women to independently obtain resources to support herself and her family. This "exchange" took place in both long and short-term relationships. A 21 year-old woman from Gaborone said, "My partner said he will give me every-

TABLE 4: Selected Specific Gender Discriminatory Beliefs as Predictors of Unprotected Sex with a Non-Primary Partner in the Past Year in the Botswana Community Survey

Statement of Belief*	N	AOR **	95% Confidence Interval
A man may beat his spouse/partner if he believes she is having sex with other men	599 (women only)	2.8	1.22-6.61
A man may beat his spouse/partner if she disobeys him	561 (men only)	3.4	1.05-11.36
It's a wife's duty to have sex with her husband even if she does not want to	561 (men only)	2.4	1.03-5.78

*The model included 5 belief statements and was stratified by sex. The other two discriminatory statements in the model were 1) It is okay for men to have more than one partner at one time and 2) It is more important for a woman to respect her spouse/partner than for a man to respect his.

**The odds ratio is a relative measure of risk, predicting the likelihood of the outcome at issue if a certain characteristic (here a particular belief) is present. The adjusted odds ratio (AOR) is the odds ratio adjusted for the possible confounding effects of the other variables included in the model. In these analyses, the variables are age, education level, monthly household income, food insufficiency, marital status, residency location, HIV knowledge, HIV-related stigma and fears of HIV-related stigma.

thing and will marry me, but I need to sleep with him without condoms." A 32 year-old woman from Serowe, now unemployed and living with her partner reported:

I had sex with men so that I can be valued. ...I worked as a domestic worker. The wife of the house left and was staying in other places. The husband asked me to have sex and I felt that I had to for money. It was very difficult because I knew he was married and I did not want to do this, but I felt like I had to because he had money.

Another woman said:

Poverty forces women to have many partners, maybe five. She needs gas, food, rent, transport — one from each partner.

Similarly, the support group founder, a single 37 year-old woman also living in Serowe and supporting two children by pooling the little money she earned with others in her household, explained:

Most women depend on men. We started income generation projects, so women can tell men to 'go away' if they don't use a condom. Because if men go away [now], we will be eating our children tomorrow.

One PLWA activist and AIDS educator noted that, "young women in Botswana are not working" and explained that he invited them to support groups and sent them to trainings "to keep them busy, so they won't go to bars, to truck drivers, looking for something to eat or something for a living."

Outside of marriage, economic dependence was reflected in intergenerational sexual relations, where younger women had sexual relations with older men with financial means. The unequal power dynamics often mean that women have little ability to negotiate the circumstances of their engagement in sexual intercourse.⁴²⁰ One 22 year-old woman described one of her past relationships:

I was never forced to have sex. I was in a relationship with an older man, he was more than 10 years older than me. ... I was given things in exchange for sex. I had trouble saying no to sex because he was supporting me. This was difficult. After he gave me money, I felt that I had to have sex.

There may also be stigma or blame, shame or loss of social status in losing a husband or partner as a result of insisting on behavior change, in addition to the economic ramifications or risk of violence in doing so. Moreover, women have been socialized to believe that

decision making within relationships and the family was the province of men. One married woman from Gaborone, who was infected with HIV through sex with her husband, described her own experience.

Women think that men are the breadwinners, and therefore they don't introduce safe sex to him. Our culture doesn't allow women to initiate safe sex. Women are too scared to say to the husband, 'I don't want you to do this.'

She further explained how girls were socialized to value men's opinions above their own and cede power to them.

... Girls learn from how their mother is in relationship with their father. The mother doesn't want to lose the husband and so does everything for him. The girl then has sex with her boyfriend because she doesn't want to lose him. So, we have to start with the girls.

As the testimony suggests, the desire to avoid abandonment by a partner was also a practical consideration given the limited economic opportunities permitting independence for women in Botswana.

A 21 year-old woman infected by a partner, with whom she was currently living, explained that he knew his status and failed to disclose it to her before she became pregnant and was tested for HIV. She stated, "Men are always regarded as the head of the family, they make the decisions alone."

Risk-Taking to Bear Children for Social Status and Economic Security

With restricted opportunities and dependent on men to provide whatever economic security they did obtain, women might seek to establish or safeguard their ties to men through bearing children in the hopes of achieving greater prospects of security.⁴²¹ Traditional social norms of masculinity which value demonstrations of virility encouraged and facilitated this view with its attendant risk-taking, as did norms that equated women's worth with childbearing. Several of the women interviewed, when asked what put women at risk for HIV, answered that proving fertility was important for both women and men. One 26 year-old single mother responded, "women want to have babies." A 29 year-old woman seeking a relationship at the time of the interview commented, "[m]en are wanting to have children and so they don't use condoms." In the absence of available means to prevent HIV transmission while permitting conception, this desire or perceived need to reproduce mitigated against HIV prevention.

Leadership on HIV/AIDS in Botswana

Community survey participants were asked about the overall performance of leaders in general in their approach to the HIV/AIDS epidemic in Botswana, interventions that would facilitate testing and their specific opinions about what could be done to encourage increased access to ARV treatment in the country. The results showed clear gaps in the performance of actors at all levels of governance and demonstrated the perceived need for stronger leadership, strengthening basic safeguards and education, innovative approaches and seizure of all opportunities to undo the stigma associated with HIV/AIDS. PLWA interviewed similarly highlighted the need for increased and more consistent leadership, particularly in the communities.

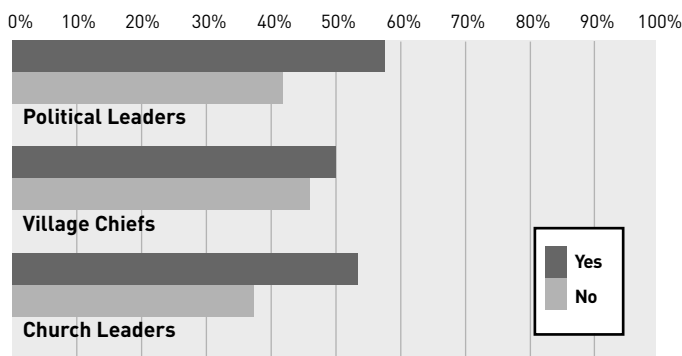
Community Survey

When asked general questions about whether national and local leaders have done enough to address the problem of HIV/AIDS in Botswana, 46 percent of women and 38 percent of men in the community survey did not believe that political leaders had done enough. Forty-seven percent of participants reported that their own village chiefs had done not done enough. In addition, 37 percent of community survey respondents did not believe that their church leaders had done enough. Results are shown in Graph 9.

Testing

It appears that community leaders (such as politicians, chiefs and church leaders), did not play a major role in terms of their personal testing practices in convincing people to undergo HIV testing in Botswana. In the community survey, among those who had been tested,

GRAPH 9: Beliefs Regarding Whether Political, Village and Church Leaders Have Done Enough to Address HIV/AIDS in Botswana, Botswana Community Survey (n=1232)



ten percent agreed that chiefs, religious or political leaders having been tested convinced them to do the same. For those who had not been tested, 39 percent of women and 48 percent of men stated that they would be convinced to test by a national HIV testing week where leaders in society such as politicians, clergy, chiefs, celebrities and sports stars would get tested.

Treatment

Community survey respondents were asked what more could be done to help more people get ARV treatment in Botswana. Results are shown in Table 5. The majority agreed that encouraging more people to get tested and improving education about treatment would facilitate access. There was less agreement on the efficacy of additional HIV/AIDS support groups, access to higher quality medical care, increasing confidentiality at treatment centers, decreasing delays, improved treatment of HIV-positive persons by doctors and nurses or provision of food assistance to those seeking treatment.

PLWA Interviews

Participants in the interviews gave mixed reports on leaders as role models in the context of HIV/AIDS. One HIV educator explained,

TABLE 5: Opinions on Interventions to Improve Access to Treatment in Botswana, Botswana Community Survey*

Statement of Intervention	Community Survey Participants N= 1267 n (%)
Encouraging more people to get tested	886(70)
Improving education about treatment	665(52)
If there were more HIV/AIDS support groups	253(20)
Increasing confidentiality at treatment centers	237(19)
If people had access to better clinics and hospitals	204(16)
Decreasing time delays at the treatment centers	180(14)
If doctors/nurses would treat people with HIV better	156(12)
Providing assistance with food	126(10)

*Respondents could give more than one reason.

I deal with many villages. Some [leaders] are good and some are not. At a panel discussion last week in one village, few came. There is one chief who is very good, who knows what I am talking about when I talk about HIV. He likes each and every activity [that we do]. As a chief and a counselor, you have to be an example to the community.

A 21 year-old woman noted the need for leadership from influential village elders.

The community stakeholders should take part in the HIV pandemic. We are young, we do the visits, and men tell us to go away. It is better for the community leaders to go [to] the families to encourage testing. If older people did it, it would make a big difference.

Another woman who works with the national network of PLWA in Gaborone praised innovative efforts by local authorities.

Communities are trying to do their best. Village elders are now recommending testing at funerals. They suggest that people say, 'O tsogile jang? A o itse seemo sa gago?' (How are you? Have you been tested?)

Some expressed concern that there were not enough community leaders willing to speak out about their own experiences as people living with HIV/AIDS. One youth counselor commented:

Most community leaders are doing a good job; however, there are no leaders coming out and saying that they are HIV-positive. People in prominent positions do not speak out, most speak about HIV/AIDS from an HIV-negative status.

An unemployed mother of one commented, that, on the other hand, some leaders only get involved in the issue if they have been personally touched by it.

The dikgosi (chiefs) and baruti (church leaders) are only getting involved when they have personal experience, when some[one] in their own family has HIV for example.

Conclusion

Results from the community survey and PLWA interviews illustrate how the HIV/AIDS epidemic in Botswana is undergirded by: 1) persistent HIV-related stigma and discrimination and attendant fears; 2) women's lack of decision making on sexual matters;

and 3) prevalent gender discriminatory beliefs associated with sexual risk-taking. Participants identified the gaps in the national response that must be addressed in order to stem new infections and provide the care and treatment needed by those infected or affected by HIV/AIDS, particularly women. In particular, all aspects of women's lack of autonomy, including food insufficiency and economic dependence on men, must be addressed in order to lessen women's vulnerability to HIV infection and its negative health, social, economic and other devastating impacts.

While the findings suggested some areas of real achievement in Botswana, such as the overall positive nature of experiences with HIV testing, they also revealed gaps in HIV knowledge and high levels of fear of stigma should an individual test positive. The latter appeared to play an important role as a key reason for why less than half the community sample had tested, despite high levels of perceived access to testing and the existence of media messages, treatment and confidentiality that were identified as facilitators by those who had tested — fear of knowing one's positive status was the most prevalent barrier.

The prevalence of sexual risk-taking, whether chosen or compelled, was of primary concern, and clearly linked to the economic dependency and low social and legal status of women in Botswana. Female community survey participants were more food insufficient, poorer and more likely to be unemployed than their male counterparts. Participants' reports demonstrated that vulnerabilities created by economic need and lack of resources translated directly into the lack of control over decision making on sexual matters for women, including sexual partnerships with non-monogamous partners and unprotected sex. Moreover, regression analysis confirms that beliefs in gender discriminatory norms predicted sexual risk-taking for women and men.

Changing these beliefs and circumstances by promoting women's equality, reforming discriminatory laws and condemning discriminatory norms and practices should be a priority for the Government. In fact, leadership was judged to be lacking on every level. Respondents nearly universally agreed in the efficacy of encouraging testing through a range of interventions and improving education about both testing and treatment, implying that although Botswana has had some laudable success in these areas, more is left to be done. In particular, participants identified concerns that these include ensuring that the routine testing program incorporates safeguards to guarantee the provision of counseling and to prevent avoidance of

health care seeking and violence against women who test. The potential for negative impacts of the testing program is rooted in the existence of HIV-related stigma and discrimination, and the vulnerability of women in a country where some significant steps towards women's equal legal rights have been made, but the goal of gender equality is as yet unrealized.

Notes

³⁹³ This represents an 88.5 percent response rate.

³⁹⁴ Currency conversion at the Interbank Rate for November 15, 2004 (1 US dollar = 4.54 Botswana *pula*). FXConverter. Available at: <http://www.oanda.com/convert/classic>. Accessed on February 13, 2007.

³⁹⁵ Derogatis LR, Lipman RS, Rickels K, Uhlenhuth EH, Covi L. "The Hopkins Symptom Checklist (HSCL): A measure of primary symptom dimensions." *Modern Problems of Pharmacopsychiatry*. 1974;7(0):79-110. This screen has been validated previously in a number of international settings in Africa and elsewhere. Bolton P, Wilk CM, Ndogoni L. "Assessment of depression prevalence in rural Uganda using symptom and function criteria." *Soc Psychiatry Psychiatr Epidemiol*. Jun 2004;39(6):442-447.

³⁹⁶ An urban village is a large village classified as urban under the Botswana census. See Buthalini D. "Methodological aspects, quality control measures and outcome: 2001 population and housing census in Botswana." Central Statistics Office. Available at: http://www.cso.gov.bw/html/census/meth2_2.html. Accessed August 28, 2006.

³⁹⁷ Women reported as follows: 18 percent had zero visits, 44 percent had 1-2 visits and 38 had 3 or more visits. Men reported fewer visits: 27 percent had zero visits, 45 percent had 1-2 and 28 percent had 3 or more.

³⁹⁸ Education data was missing for one interviewee.

³⁹⁹ Participants were asked 15 questions about their knowledge of HIV transmission and prevention, based on questions modified from the UNAIDS General Population Survey and the DHS (demographic health survey) AIDS module. See <http://www.emro.who.int/gfatm/guide/tools/dhsaids/dhsaids.html>. Using the UNAIDS knowledge indicator scoring system, individuals were scored as having correct HIV knowledge if they correctly identified the two most common modes of HIV prevention in Botswana (consistent condom use and abstinence).

⁴⁰⁰ The other characteristics were age, sex, monthly income, marital status, residency location, self-reported overall health status, perceived availability of ARV treatment, HIV knowledge, HIV-related stigma, fears of HIV-related stigma and a positive screen for depression.

⁴⁰¹ Through the PMTCT Plus program it is possible for male partners to get tested for HIV at antenatal clinics. Available at: http://www.pathfind.org/site/DocServer/FP_HIV_Integration_web_copy.pdf?docID=3461. Accessed on April 5, 2006.

⁴⁰² All questions asked respondents about the most recent time they were tested.

⁴⁰³ While those that tested because they were sick may have felt, in the broad sense, that they "had no choice" because their physician needed to determine the cause of their illness, that proportion of respondents (21 percent of women and men) does not account for the larger group that reported not being able to refuse the test. In this group, some may have felt a personal imperative to find out the cause of their illness and thus that they could not, in that sense, refuse the HIV test.

⁴⁰⁴ [cross ref limitations sub-section in Methods]

⁴⁰⁵ As stated earlier, 85 percent of women and 90 percent of men surveyed reported the belief that treatment would be available to them if they had AIDS.

⁴⁰⁶ The following explanation was given of the policy of routine testing: "Routine testing is a new approach to HIV testing announced in January 2004. It means that almost everyone who visits a health clinic or hospital will get a number of tests, including an HIV test, unless they say no to it."

⁴⁰⁷ Sixty-two percent of those in the community survey who reported testing had tested after the introduction of routine testing.

⁴⁰⁸ Respondents were asked 7 questions adapted from the UNAIDS general population survey and the DHS (demographic health survey) AIDS module. Following the UNAIDS scoring system, any participant who reported a stigmatizing/discriminatory attitude on any of 4 principal questions was categorized as having such attitudes.

⁴⁰⁹ These additional questions about projected stigma were asked in order to counter the influence that wanting to give the "correct" answer (social desirability bias) might have on participants' responses to the more general stigma questions.

⁴¹⁰ This projection contrasts with the 8 percent of women and men who reported that they would kick an HIV-positive spouse or partner out of the home.

⁴¹¹ Based on survey responses, PHR created a 9-item index on "projected HIV stigma" with higher scores on a continuous scale of 0-9 associated with a greater number of reported adverse social consequences associated with testing positive. The mean score for men was 2.04 (plus/minus a standard deviation of 2.07) and for women it was 1.67 (+/- 1.76), a statistically significant difference.

⁴¹² "Sexually active" is defined as having had at least one sexual partner in the past 12 months.

⁴¹³ The latter is a traditional indicator or predictor of high-risk sexual practice (a practice likely to lead to HIV transmission), given that a non-regular sexual partner is also likely to be non-monogamous, the couple is less likely to be seeking pregnancy and HIV status is less likely to be disclosed between such partners.

⁴¹⁴ This association was also statistically significant for men reporting lack of control. In regression models "lack of control" was defined as your partner usually or always deciding when you have sex. Analyses were adjusted for other participant characteristics: age, monthly income, marital status, residency location, fair or poor health status, frequency of visits to a medical doctor, alcohol use, HIV testing, HIV knowledge, HIV-related stigma, a positive screen for depression and experience of an intergenerational sexual relationship.

⁴¹⁵ AOR: 3.04, 95% CI (1.31-7.04).

⁴¹⁶ AOR: 1.79, 95% CI (1.12-2.86).

⁴¹⁷ This variable was constructed from responses to 14 statements, including affirmative responses to 6 items expressing discriminatory beliefs, negative responses to 2 items endorsing women's rights and 3 pairs of variables expressing different expectations concerning the roles of women and men.

⁴¹⁸ 95% CI (1.01-7.1).

⁴¹⁹ 95% CI (1.08-11.99).

⁴²⁰ Social norms and status differentials related to age and gender also contribute to this dynamic.

⁴²¹ In the community survey, 21 percent of women and 27 percent of men agreed that a woman must prove her fertility before she can marry and 20 percent of women and 27 percent of men affirmed that a man must do so.