# A STUDY ON MEN'S PERCEPTIONS OF THE EFFECTS OF HIV/AIDS ON CHILDBEARING IN AN INFORMAL SETTLEMENT IN FRANCISTOWN (BOTSWANA)

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment for the Degree, Master of Science in Nursing (Midwifery)

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Johannesburg, March 1999

# DECLARATION

I, Tinaye Sonto Mmusi declare that this research report is my own work. It is being submitted for the degree, Master of Science in Nursing in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signed:----------

TINAYE SONTO MMUSI

This ----------02----------Day of ----------09----------1999

# DEDICATION

I dedicate this work to my husband, Mmusi and my children Thato and Sethunya who have continuously encouraged and supported me throughout my period of study. My appreciation also goes to my sisters and all other family members who have tirelessly cared for my children in my absence.

Lastly I would like to thank my parents, the late Mr K. Seeletso and Mrs O. Seeletso who inspired an yearning for education.

# ACKNOWLEDGEMENTS

I would like to thank the following people without whom the research report would not have been possible.

My supervisor, Patricia McInerney and co-supervisor Barbara Lester for their support and encouragement and for inspiring an academic zeal.

The Epidemiology Unit, Gaborone, Botswana for the time and support everyone gave me, especially Dr Moeti for allowing his unit staff to offer assistance and Mrs Sheenaz Halabi for assistance with statistical analysis of the data.

My sister, Mrs Lini Maruatona for typing the report.

The Office of the President, Gaborone, Botswana for granting permission to conduct the study.

All the men who participated in the study.

# ABSTRACT

The study sought to establish men's perceptions of the effects of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) on childbearing in an informal settlement in Francistown (Botswana). The survey method was employed. Systematic random sampling was used to obtain the sample (n = 197) from a population of 1768 men aged 18 years and above. An interview schedule was used. Use was made of both open and closed ended questions. The interview sought to describe both demographic and other variables on men's perceptions of HIV/AIDS in childbearing.

Data was analysed using the Epi Info. Version 6 Statistical Package. The findings revealed that almost all of the men interviewed (98.0%), possess some sound knowledge on HIV/AIDS. Further, the study suggested that men associate HIV/AIDS with various physical and emotional effects on different people. It was found that men relate emotional stress with concern about death of those affected. They however, mentioned other emotional concerns, such as the welfare of dependants following death of a parent, contracting infection and caring for ill relatives. Findings showed that men could generally perceive the social implications of HIV/AIDS in childbearing. Responses on men's perceptions of cultural issues demonstrated that culture exerts an influence in childbearing decisions. Finally several issues arose on HIV/AIDS such as how the virus that causes AIDS came into being. The study further revealed knowledge gaps such as in AIDS treatment.

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# CHAPTER 1

## INTRODUCTION

Since the discovery of the Human Immunodeficiency Virus (HIV), one of the major ways of combating the infection has been through research. Research has been directed towards the virus itself, and various groups of people in order to attain a greater understanding about the condition. Such understanding would facilitate development of preventive strategies and/or a cure. However, until recently not much research has been conducted on men concerning HIV/AIDS. This sparsity of information/knowledge has resulted from the trends reflected in the epidemiology of HIV. In the past three to five years researchers have recognised the increased need to conduct more research on men as a way of curbing the increasing rates of HIV among heterosexuals and other vulnerable groups for example women. In order to comprehend this need for involving men more in HIV/AIDS studies, it is necessary to understand the various efforts previously aimed at managing the condition as well as its epidemiological evolution. Before discussing studies involving males' role in relation to the transmission of the virus, a brief historical background of the evolution of the disease and its causes will be discussed.

### 1.1 HISTORICAL BACKGROUND

Since its discovery in the 1980s, the HIV epidemic has posed challenges concerning its treatment and eradication. The greatest difficulty regarding treatment lies in the capacity of the virus to change rendering it almost impossible to eradicate. Johnstone, McCallum

and Brettle (1998 p1185) stated that, "indeed the rapid viral cycles and generation of mutants make for the fastest genome evolution described. For this reason, despite the availability of very potent anti-viral drugs, treatment has been characterized by phases of hope and disappointments". Johnstone further notes that the immunopathology resulting in progressive destruction and then collapse of the immune system is not yet completely defined. This creates challenges for the obstetric fratenity. HIV/AIDS related problems arise in the various phases of the childbearing process. Vertical transmission of the virus has been one of the major concerns to researchers (Johnstone, McCallum & Brettle, 1998). Other concerns include the possible adverse effects of pregnancy and other childbearing processes on HIV progression as well as the effects of HIV/AIDS on pregnancy outcome. To date, a cure to alleviate such problems has not yet been found. In addition, prevention strategies aimed at controlling the spread of the virus have not been successful. In view of this difficulty, researchers focused on groups deemed to be at high risk.

### 1.1.1 PREVENTIVE STRATEGIES AND HIGH RISK GROUPS

The realization that it could be a long time before scientists discover a cure, has led to intensified research efforts directed towards prevention of transmission of the virus. Initially, this prevention, which depends on positive behavioural change, was aimed at groups deemed to be at high risk of contacting infection. Thus more research was conducted in groups such as homosexuals and drug users. However, strategies to contain the spread of the virus did not appear to achieve their objectives because the infection rate increased within these groups. Furthermore, the virus was being detected in other population groups (Kline, Kline & Oken, 1992; Misener & Sowell, 1997). Thus a new

trend was developing. A shift in the focus of preventive strategies was necessary to accommodate the emerging trends in the epidemiology of HIV.

### 1.1.2 PREVENTIVE FOCUS SHIFTS TO WOMEN AND HETEROSEXUALS

Until the late 1980s the focus on high risk groups led to women's and heterosexual's vulnerability to HIV being considered of lesser concern to a majority of researchers (Misener & Sowell, 1997). However, the demographic characteristics of individuals affected by HIV are reported to have changed and continue to do so. Reports currently associate HIV infection with sexual transmission (among heterosexuals) and vertical transmission, as well as increased transmission among women (Misener & Sowell, 1997). Concerning prevalence among women, Kline, Kline and Oken (1992 p447) noted that, "the incidence of HIV infection in women is growing at a proportionately faster rate than in any other population group". As a consequence of these new trends, a demand arose to investigate heterosexuals and women in particular. At this point, in addition to the groups that had been initially deemed "high risk", heterosexuals and women also became important. Women were seen to be especially vulnerable, and therefore research into men's contribution to the spread of the disease remained limited.

### 1.1.3 THE NEED TO INCREASE MALE INVOLVEMENT IN STUDIES CONTRIBUTING TO HIV PREVENTION

The shift in research reflected above, has ignored the impact made by men on both transmission of the infection among heterosexuals and women. Amaro (1995) alludes to

the influence that men have on women in heterosexual relationships. He states that men control condom use and that this is culturally determined. Considering this impact it is important to investigate men as a group in order to understand their influence on other vulnerable groups as well as the risks they pose to themselves. A report by the AIDS/STD Unit (1998) indicated that in Botswana various methods have been implemented to prevent HIV and enhance awareness. Compared to women, men have been involved to a lesser extent in the prevention of HIV transmission and in enhancing awareness of the condition. HIV/AIDS prevention programmes attempting to institute sexual behavioural change among heterosexuals have not been very successful.

## 1.2 RESEARCH QUESTION

The study undertakes to answer the question, "what are men's perceptions of the effects of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) on childbearing in an informal settlement in Francistown (Botswana)?"

## 1.3 THE PURPOSE OF THE STUDY

The purpose of the study is to reveal what men believe to be the medical, social and emotional outcomes of a co-existent status of HIV/AIDS and childbearing. The study also attempts to determine men's opinions of peoples' responsibilities in decision- making in childbearing in relation to HIV/AIDS.

Currently there is support for studies addressing cultural, structural and other conditions

enhancing heterosexual and women's vulnerability to HIV infection. In most cultures, particularly in Africa, the sexual role that men play in heterosexual relationships appears to contribute negatively to the spread of HIV. Thus a demand to study their sexuality in the context of culture arises in order to determine their input in heterosexual relationships. This study on men's perceptions is an effort to understand aspects of men's sexuality in relation to HIV/AIDS in childbearing.

Men's beliefs about control and responsibilities in heterosexual relationships would serve as a base from which to analyse influence on sexual practices in these relationships. Such analysis would enable development of HIV preventive strategies. These strategies would focus on discouraging negative influence and enabling the other partner to resist the influence.

## 1.4 STATEMENT OF THE PROBLEM

The HIV infection rate is increasing rapidly in Botswana, as in most African countries. Estimates based on epidemiological evidence in 1994 indicate that almost 100 individuals are infected with HIV in Botswana daily. If this infection rate is maintained, the population of 1.5 million will be infected in a five year period.

Epidemiological trends existing in other countries are also evident in Botswana. WHO statistics as stated by Chipfakacha (1997) reveal that about 4.5 million women in Africa are infected with HIV. In Botswana the ratio of infection between men and women is 0.83 to 1

(AIDS/STD, 1997). Infection is highest among young adults between the ages of 12 and 29 years (Seboni, 1997). Seboni (1997) further notes, that in 1996 females accounted for 68% of HIV/AIDS statistics. It can be assumed that the bulk of infection occurs amongst heterosexuals since it is the predominant sexual orientation adopted by the Botswana population.

For the people of Botswana, the epidemic imposes grave effects on the whole population. These effects include an increase in mortality from tuberculosis (TB) and, a rise in the incidence of sexually transmitted diseases. Furthermore, the infection is contributing to the large number of orphans in the country. The National AIDS Control Programme (NACP35, 1995) estimates that by the year 2000, HIV will have contributed to the estimated 65 000 orphans aged 15 years and less. Given the fact that heterosexual transmission of the virus has been identified as a significant contributory factor in the spread of the virus and the disease, both men's and women's roles should be investigated. Studies (Kline, Kline & Oken, 1992; Misener & Sowell, 1997) have sought to determine women's role in the spread of the virus, but there appears to be limited information about men's perception of the virus, especially in relation to childbearing. In Africa, where women are subservient to men, it is important to determine men's understanding and perceptions of the disease, if health education programmes are to make any impact on the population.

## 1.5 THE SIGNIFICANCE OF THE STUDY

There is a paucity of research on men's perceptions of HIV/AIDS in childbearing. In addition, research in this area has not focused on childbearing issues.

As previously illustrated HIV/AIDS raises certain gender issues. This is an area that is currently receiving a lot of attention worldwide (Fullilove, 1990; Frieze & McHugh, 1992; Giffin, 1998). Solutions to gender problems are far from satisfactory as pressure groups and society at large are still struggling to conscientize and empower women to improve their status, including health.

An assessment of men's perceptions of HIV/AIDS on childbearing as well as power issues concerning childbearing decisions may indirectly reveal the manner in which men influence childbearing decisions and women's sexual behaviours. Knowledge of this will enable formulation of gender specific programmes for surveillance, prevention and care of HIV/AIDS patients.

## 1.6 THE OBJECTIVES OF THE STUDY

The objectives of the study were to identify:-

1.6.1 the demographic characteristics of the respondents,

1.6.2 knowledge possessed by men on HIV/AIDS,

1.6.3 the medical effects of HIV/AIDS on childbearing as viewed by men,

1.6.4 the emotional effects of HIV/AIDS on childbearing as viewed by men,

1.6.5 the social effects of HIV/AIDS on childbearing as viewed by men,

1.6.6 men's perceptions regarding responsibilities concerning decision-making in childbearing in relation to HIV/AIDS and

1.6.7 any association emerging between demographic information and responses.

## 1.7 LIMITATIONS OF THE STUDY

The study has the following limitations:

1.7.1 The fact that the study was conducted by a woman on men may have biased their responses to some extent.

1.7.2 The specific location of the study (informal settlement) makes results less generalizable to other groups of men found in different settings.

1.7.3 Bias may have been introduced as respondents were asked to describe behaviours or feelings that society may judge to be wrong or unusual.

1.7.4 The difficulty in analysis of open-ended questions arising from categorizing questions for coding purposes results in some researcher bias and loss of some information.

1.6.3 the medical effects of HIV/AIDS on childbearing as viewed by men,

1.6.4 the emotional effects of HIV/AIDS on childbearing as viewed by men,

1.6.5 the social effects of HIV/AIDS on childbearing as viewed by men,

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## 1.8 DEFINITIONS

The following terms are operationally defined.

PERCEPTIONS

Feelings, ideas, beliefs, opinions and any other ways in which men regard HIV/AIDS to affect childbearing.

MEN

Any male person over the age of 18 years.

EFFECT

Any outcome resulting from a co-existent status between HIV/AIDS and childbearing.

CHILDBEARING

A process occurring prior to pregnancy, during pregnancy, labour, delivery and the post-natal period.

DECISION-MAKING RESPONSIBILITIES

Any obligations that one has in making plans.

RELATIONSHIP

Any impact that exists between HIV/AIDS and childbearing or between men and women.

## 1.9 ABBREVIATIONS

| | |
|---|---|
| HIV: | Human Immunodeficiency Virus |
| AIDS: | Acquired Immunodeficiency Syndrome |
| WHO: | World Health Organisation |
| NACP: | National AIDS Control Programme |
| TB: | Tuberculosis |
| STD: | Sexually Transmitted Disease |
| NAC: | National AIDS Council |

## 1.10 CONCLUSION

This chapter provided an introduction to the research study. The problem was identified and outlined. The arising research question was stated and the objectives of the study were identified. The limitations of the study as well as operational definitions were presented.

# CHAPTER 2

## LITERATURE REVIEW

### 2.1 INTRODUCTION

In this chapter the literature reviewed will be discussed. The discussion will refer to:

2.1.1 HIV/AIDS in childbearing in Botswana as it relates to the global situation.

2.1.2 Studies addressing reproductive decision-making in view of HIV/AIDS and peoples' perceptions of the effects of HIV/AIDS on childbearing as they pertain to the medical, social and emotional aspects in Botswana.

2.1.3 Behaviours linked to reproductive decisions as they relate to HIV spread.

2.1.4 HIV preventive strategies particularly those that have utilized cultural factors to eliminate barriers to behavioural change.

### 2.2 HIV/AIDS IN CHILDBEARING IN BOTSWANA AS IT RELATES TO THE GLOBAL SITUATION

Since detection of the HIV in the early 1980s the condition has become pandemic, affecting all continents and countries in the world. The World Health Organization (WHO) estimated that 22 million people were infected (including 800,000 children) and 8.4 million had AIDS in 1997 (Thuriax & Cherney, 1997). Africa and other developing countries are most affected. However, by June 1996 the WHO had already estimated that Sub-Saharan Africa was the most affected region of the world with approximately 12.5 million people

being HIV positive (Chipfakacha, 1997). At that stage the world's population was estimated to be 18.5 million. Furthermore, the spread of HIV appears to be more concentrated in specific areas of Sub-Saharan Africa, such as Botswana, Zimbabwe, Zambia, Uganda and Malawi. These countries constitute 12% of the HIV statistics worldwide (Chipfakacha, 1997).

In Botswana the first HIV related illness was reported in 1985 (The National AIDS Control Programme (NACP36, 1995)). Despite the fact that the virus reached Botswana somewhat later than other Sub-Saharan countries, the infection has spread at an alarming rate and is threatening the scarce population of the country (NACP4, 1992). Though Botswana is vast in size, the Central Statistics Office (CSO), projected a population of 1495 999 for 1996 (NACP4, 1992). The infection spread so fast that it was predicted that by 1999 about 13% of the population would be infected (National AIDS Council (NAC), 1996).

Most of the infected people in Botswana are young adults, mainly women and children (NACP36, 1995). This follows a trend in most parts of the world, where women suffer disproportionately from AIDS since they are affected more than men. According to Kline, Kline and Oken (1992p 447), this was said about the trend "the incidence of HIV infection in women is growing at a proportionately faster rate than in any other population group". The NACP36 (1995) reflects an infection ratio of 0.83 male to one female in Botswana. There are various reasons why this trend prevails. Some of these reasons have their roots in gender issues, whereby men directly or indirectly contribute to the increased vulnerability of women to HIV infection. Despite this state of affairs, it was not until the second half of the 1980s that "women vulnerability to AIDS became a concern to a

majority of researchers" (Giffin 1998 p151). However, such realization led to focusing of attention on female sexuality. This attempt at HIV/AIDS prevention ignored the fact that "a woman is only one participant in decision-making" (Vinier, Ross & Akande, 1998 p314). As a result, some of the risky behaviours women exhibit are dependant on their roles in the sexual relationship and are influenced by men. Therefore understanding men's impact on women in heterosexual relationships could facilitate strategies aimed at bringing about positive behavioural change in both sexes.

The situation of HIV/AIDS in childbearing in Botswana is further aggravated by the population's youthful structure in which approximately 90% of the people are below the age of 50 years (NACP4, 1992). "AIDS strikes selectively at the young and people in the prime of life" (Thuriax and Cherney, 1997 p20). This has led to consideration of various efforts to deal with the problem. In this regard, there is need to investigate the influence of socio-cultural relationships on HIV transmission. In line with this need, some studies (Giffin, 1992; Johnstone, 1996; Kline, Kline & Oken, 1992; Sowell & Misener, 1997), concerning perceptions about HIV/AIDS (within the context of relationships) have been conducted. These studies are reviewed below.

## 2.3 STUDIES ON PERCEPTIONS REGARDING HIV/AIDS

Though researchers in the past have not placed emphasis on studies investigating the perceptions of men in order to understand the high prevalence rate of HIV/AIDS among women and other groups, this has begun to gain momentum. In most African countries the

commonest way of spreading the infection is through heterosexual relationships, in which context at least two people are involved in the transmission of the virus (Giffin, 1992). Furthermore, not only men and women are affected by the viral transmission in heterosexual relationships. Unborn infants also acquire the virus through vertical transmission. Therefore, research (Johnstone 1996; Kline, Kline & Oken, 1992; Sowell & Misener, 1997; Bowser, 1992) has been conducted into perceptions concerning reproductive decision-making in relation to HIV/AIDS, general and men's perceptions of HIV/AIDS.

### 2.3.1 REPRODUCTIVE DECISION-MAKING IN THE CONTEXT OF HIV/AIDS

Several studies (Johnstone, 1996; Kline, Kline & Oken, 1992: Sowell & Misener, 1997; Bowser, 1992) have been conducted in the West on reproductive decisions made by women in the context of HIV/AIDS. Despite the fact that these studies were addressing women, all probed for men's influence on women's decision-making and thus laid groundwork for further studies on men's perceptions. Contrary to traditional belief, some findings in those studies revealed that women exercise a degree of independence in heterosexual relationships (Sowell & Misener, 1997; Bowser, 1992). As a result women could make some reproductive decisions without men's influence, for example, terminating a pregnancy if they are HIV positive.

### 2.3.2 GENERAL PERCEPTIONS ON HIV/AIDS

In Africa the need to conduct studies which looked at general perceptions about the virus began to be appreciated in the early 1990s (Mbengashe, 1996; Vinier, Ross & Akande,

1997). Although findings in these studies show possession of knowledge of HIV/AIDS, gaps still exist. Myths and false beliefs were also revealed.

Despite the fact that several research (Johnstone, 1996: Kline, Kline & Oken, 1992: Sowell & Misener, 1997; Bowser, 1992) studies in America among black minorities oppose the assumption that normally accepted cultural norms could be responsible for inhibiting behavioural change for both men and women, studies in Africa reveal contrasting results. According to Vinier, Ross and Akande (1997 p313), "prevention efforts in Africa as in other countries have met with some difficulties. Factors influencing prevention include the natural history of HIV infection and AIDS in the context of current health issues in Africa, current beliefs about HIV and AIDS, and the social and cultural context of HIV/AIDS in Africa". In most parts of Africa people still practise various behaviours that promote HIV transmission, which are ingrained in cultural influence. For example, an African woman may not insist on condom use if her husband dissents, because subservience is encouraged among women. Hence sexual issues which are culturally determined are key factors which need to be considered in designing preventive strategies to HIV infection.

Findings from studies on gender role differences resulting in power gradients led to concern about empowerment of women to bridge the power gap in HIV/AIDS control. Authors such as Beeker, Guenther-Grey and Ray (1998) and Giffin (1992) have produced position papers looking at women's empowerment as a paradigm drift in HIV/AIDS prevention. In their papers they acknowledge the importance of research on cultural aspects of sexuality, which Giffin (1992 p158) refers to as "gender-sensitive AIDS

research".

### 2.3.3 MEN'S PERCEPTIONS ON HIV/AIDS

In Botswana, researchers have been prompted to focus their studies mostly on women because of the prevalent trend of greater HIV infection in women as in other parts of the world. However, the situation is changing. According to the AIDS/STD Unit report (1998 p6), "men must be addressed because they traditionally dominate women in sexual matters". Currently, the same unit is conducting a study entitled, "Men, Sex and AIDS" in the country. This study and others are likely to bring about a comprehensive understanding of the socio-cultural influences on HIV spread in the country, setting a springboard from which preventive programmes can be formulated. Findings of the study will further complement the lack of research data pertaining to men and HIV/AIDS in the country.

## 2.4 MEDICAL EFFECTS OF HIV/AIDS IN CHILDBEARING IN BOTSWANA

The literature reveals a wide array of medical problems resulting from HIV/AIDS. Botswana is beginning to experience most of these as the disease progresses. The medical effects cause a strain on the health sector and on the economy in general. In 1989, there were 145,000 patients treated for sexually transmitted diseases (STD). In 1992, in one surveillance site, 22% of STD patients were HIV positive in 1992 (NACP4 1992). A later survey in 1994, revealed that 53.8% of men attending STD treatment clinics in

Francistown were HIV positive (NACP24, 1994). STDs have a direct negative bearing on HIV/AIDS in childbearing due to their mode of transmission. Required sexual contact for childbearing places one at risk of contacting an STD and/or HIV. Each of the two conditions increases vulnerability to the other. In the past the problem of STDs was accorded low priority because they were treatable leading to low mortality and were subject to minimal stigmatization. Today, with the advent of HIV/AIDS, diagnosis and management of STDs is given greater priority. Despite these attempts, STDs in conjunction with HIV are bound to cause ravages in Botswana as evidence of their increase is apparent in surveillance studies (NACP4, 1992).

Tuberculosis (TB) which was easily controlled in the past, has increased. An estimated 11 000 people are expected to have TB by the year 2001 due to the increasing incidence of HIV/AIDS (NACP4, 1992). This figure would be three times the number of TB patients in 1992. Thirty one percent of all TB patients in one study area were found to be seropositive (NACP4, 1992). This demonstrates the association between HIV and opportunistic infections of which TB is one. In Botswana, observation has shown that more HIV patients with TB die than those without TB (NACP4, 1992). If TB were to contribute to increased maternal mortality in Botswana, more disadvantages would be incurred in the childbearing area. These hazards would be heightened by the fact that the tubercle bacillus is capable of crossing the placental barrier during pregnancy. This has direct implications on foetal and infant/child health as well.

Since 1992, Botswana has been conducting annual sentinel surveillance surveys among

women attending ante natal clinics. From these HIV seroprevalence studies, it was shown that in Francistown the prevalence rate among pregnant women was 29.7%, that is almost one in three pregnant women was HIV positive. Such a situation increases the risk for vertical transmission. There is more than a 30% chance of transmitting HIV infection from a pregnant woman to offspring in Africa (Johnstone, 1996). In Botswana, about 5000 infants and children are infected and are likely to die from AIDS before their fifth birthday (NACP4, 1992). According to the then Assistant Minister of Local Government, Lands and Housing, the Honourable Mokgothu (NACP4, 1992 p6), "AIDS not drought is likely to be the major cause of weight loss among children in this decade". The statement is evidence that HIV/AIDS in childbearing is a major concern that no longer affects the health fraternity alone.

Vertical transmission of the virus during pregnancy is likely to reverse the achievements made in child health in the past. Compared to other African countries Botswana has had a lower infant and child mortality rate. However, this is likely to rise in the future because of HIV/AIDS. Johnstone (1996 p1184) reports that previous research in the West suggested such a state for the developing world when he stated "(By) current estimates ..... there will be reversals of many of the hard won improvements in child survival which have been achieved in developing countries". Literature relating to other areas such as the effects of HIV/AIDS on pregnancy, delivery, the post-partum period and breast feeding was not available for Botswana.

## 2.5 EMOTIONAL AND SOCIAL EFFECTS OF HIV/AIDS IN CHILDBEARING IN BOTSWANA

Globally, HIV/AIDS has induced a number of emotional problems in individuals, communities, societies and nations. Attitudinal studies have been conducted in various parts of the world and have revealed strong stigmatization of HIV/AIDS sufferers (Forster, Makufa, Drew, Mashumba & Kambeu, 1997; Hodgson, 1997; Zungu & Matsane, 1996; Ross, 1997; Timberlake, 1996). Stigmatization was also emphasized as a problem by May and Malmeister (1996) who pointed out that literature reveals an avoidance response towards HIV/AIDS patients. In Botswana the problem is rife, compounded by factors associated with developing countries and a highly rural population. Matters of sexuality are held in confidence in most rural communities and this may aggravate stigmatization of sexually transmitted diseases. A statement in the July report of the (NACP4, 1992 p15) also refers to the problem of stigmatization. The report states that, "it is recognized that AIDS creates special problems of rejection, ostracism and isolation, fears, social stigma and strains on family life". Besides creating a lot of emotional stress, these problems may further act as a barrier for women in seeking care for HIV/AIDS in childbearing. This in turn is likely to make things worse for them. According to the NACP4 (1992 p8), "the social stigma often associated with AIDS will increase the difficulty women have in finding care, once ill with AIDS".

HIV/AIDS has led to a diversity of problems in the various social spheres worldwide. The literature reviewed reflects some of the social implications of HIV/AIDS in Botswana. A

major effect on the educational sector has been predicted. "Trained teachers, a valuable resource in Botswana, fall mainly in the age group with the highest HIV infection rates. As they fall ill, absenteeism and staff shortages will result" (NACP4, 1992 p 11). One may presume that these problems specified about teachers, apply to virtually all labour sectors. The same report further states that students are leaving school because parents affected by AIDS can no longer afford schooling, while others leave school to care for ill parents. Young school age children with AIDS themselves will have difficulty continuing education. According to Seboni (1997, p29) "in Botswana the prevalence rate is highest among young adults who are between the ages 12 and 29 years". Botswana has recently launched a home-based care programme for terminally ill patients due to the strain exerted by AIDS patients in health care facilities. Most terminal AIDS patients die leaving children behind. Rough estimates indicate that at least 13 000 children under the age of 15 will have lost both their mother and father by the year 2001 (NACP4, 1992 p20). Thus, orphans are another problem facing Botswana. In addition all the multifaceted economic and social consequences of AIDS are placing unprecedented strains on the Botswana family (NACP4, 1992).

The NACP4 (1992) goes further to predict some of the myriad ways in which AIDS is likely to affect Botswana's economy. Reduced productivity resulting from ill-health is likely to lead to economic impairment. More funds would be required for the additional health and social programmes for HIV/AIDS sufferers. A decrease in the size of the workforce is foreseen as lives are lost because of AIDS. As a result there would be a need to recruit expatriates, which would cost the Botswana government more. Most employees'

pension funds would be affected, and the employees would not be able to support themselves when they were no longer able to work. This results from the fact that the prevalence is highest among young people leading them to leave work before they have accrued much in terms of pension and unemployment funds. These socio-economic effects, among others, were predicted at the World Economic Forum, Switzerland, where it was projected that by the year 2005 the impact of HIV/AIDS could depress the global economy by 4% of the United States Gross Domestic Product (Timberlake, 1996)

## 2.6 BEHAVIOURS LINKED TO CHILDBEARING DECISIONS AS THEY RELATE TO HIV/AIDS

It cannot be denied that certain risky behaviours linked to childbearing decisions performed by both men and women perpetrate the spread of HIV/AIDS. These behaviours like others have their base in cultural influence. It is important therefore to understand people's beliefs of HIV/AIDS, so that preventive strategies can build upon cultural influence and gender roles to combat HIV/AIDS spread. Vinier, Ross and Akande (1998 p313) stated "as on all continents, one problem with AIDS prevention is understanding the population's current beliefs concerning HIV and AIDS". International research has shown power differences in childbearing decisions between men and women (Da Vincenzi 1997; Tiedje, Fisher and Boahene, 1996; Lopata 1993; Hock, McBride and Gnezda 1989). Practices such as these are likely to worsen HIV spread.

In Botswana a lot has been done to prevent HIV infection. However, "HIV/AIDS

prevention programmes focusing on sexual behavioural change among heterosexuals have had limited success" (AIDS/STD Unit, 1998 p7). This failure is attributed to the fact that there is no comprehensive understanding of gender differences in HIV risk behaviours. Insight into these differences would be gained by considering the socio-cultural determinants of sexual behaviour and how behaviour is influenced by gender roles. This would further clarify how women and their offspring are put at risk by both their own behaviour and by the behaviour of their partners. In addition, the behavioural risks to which men expose themselves would be determined. They could then be assisted appropriately.

A pilot study entitled, " Men, Sex and AIDS" conducted by the AIDS/STD Unit between 1997 and 1998 provided some information on men's knowledge on HIV as well as certain cultural beliefs, for example, that men should control sexual matters. This information implied negative behaviours which could impede HIV infection control. In support of this project on men, the AIDS/STD Unit (1998 p6) argued that, "men must be addressed because they traditionally dominate women in sexual matters". The study revealed some misconceptions and myths held by men which are likely to lead to risky behaviours. Some men believed that the condom lubricant harbours the HIV virus, while others thought AIDS was for unlucky people. A traditional cure is believed to exist for AIDS and yet others believed AIDS is curable like other diseases. Furthermore, some men thought the AIDS situation in Botswana is over-imagined. In addition, the study mentions an imbalance in social and cultural conditions resulting in men translating their power into certain detrimental behaviour patterns. Evidence to practices of power imbalance can be

seen in the following statement - "men are more likely than women to initiate, dominate and control sexual interactions and reproductive decisions" (AIDS/STD Unit, 1998 p8). Examples cited in the study illustrating risky behaviour patterns include rape, incest and physical violence. All these are regarded as barriers in HIV prevention especially among women as they are the victims. The AIDS/STD Unit (1998 p8) further observed that, "the existing male-female sexual interaction patterns create formidable barriers for women to adopt HIV risk reducing behaviours". In reaction to situations such as these, the executive director of UNAIDS (Thuriax & Cherney, 1997) has stressed the importance of upholding human rights in AIDS control. He said, "rape inside and outside marriage, incest, forced prostitution, sexual battering, harmful traditional practices and any kind of coerced sex, place women and girls at higher risk of contacting infection" (Thuriax & Cherney, 1997 p25). Sexual abuse and other forms of violence are reported to be on the increase (AIDS/STD Unit, 1998).

The social construct of feminism in Botswana emphasizes sexual innocence, virginity and motherhood as valuable cultural attributes. The strong emphasis on virginity limits young women's ability to seek information or talk about sex (AIDS/STD Unit, 1998). This is likely to prohibit them from reporting acts of sexual abuse which are on the increase. The perceived ideal of "motherhood" places women in a serious dilemma of having to choose between prevention and fulfilment of a social role. This sometimes has a negative impact on women, leading them to making inappropriate childbearing decisions, such as falling pregnant when aware of a seropositive diagnosis. Giffin (1998 p156) said, "in some cultural groups, a woman is not complete until she is a mother and having more children

strengthens her role in the culture".

Despite the negative cultural influence in some instances, in the developed world things are beginning to change. Recent literature reveals that women's attitudes are no longer typically congruent with traditional gender roles. Participants in some of these studies express a remarkable degree of independence in their relationships with men. According to Kline, Kline and Oken (1992), in the West this independence was shown partly by their readiness to relinquish these relationships if they no longer satisfied them. There is a contradiction though, since some literature still confirms a situation of inequalities between sexes (Giffin, 1998). Women's lack of power in intergender relations is believed to be heightened by their lack of options for material survival outside these relationships. One can only hope that gradually, as women become economically and socially empowered, the situation will change for the better in Botswana. Currently the best that can be done is to seek and engage in the most appropriate strategies of HIV prevention; those that are gender and culture specific.

## 2.7 PREVENTIVE STRATEGIES TO HIV INFECTION

Currently women have become a major focus of AIDS prevention campaigns. The significance of such an approach can not be doubted in view of the rate at which HIV infection is growing among them, as a population group. Most of these strategies include attempts to empower women in order to effect positive behaviour change. However, most of them do not acknowledge the fact that sexual behaviours occur within the context of a

relationship and in most cultures are controlled by men and also determined by the role women play in these relationships. Amaro (1995 p52) said this of condom use; "condom use is a sexual behaviour that is clearly under the control of men and is embedded in a socially sanctioned inequality between men and women". Likewise, several other sexual behaviours and reproductive decisions by women are greatly influenced by men. Preventive strategies need to capture this factor in order to appropriately address issues of gender and culture as barriers to HIV prevention. Beeker, Guenther-Grey and Ray (1998), questioned interventions designed only to change health-specific attitudes and competencies. They indicated that such programmes can only benefit highly motivated participants but do little to address cultural, structural and other conditions enhancing women's vulnerability. To substantiate it further, Vinier, Ross and Akande (1997) commented that many programmes have been criticized for not taking into account women's role in relationships. All this indicates that it is imperative to understand men's influence on women's decisions pertaining to HIV prevention and childbearing. Studies on their perceptions in this area would reflect their likely influence on women as it applies in several relationships and reproductive decisions. The behaviours that are likely to put men at risk would be also be determined.

In Botswana control of HIV spread is co-ordinated by the National AIDS Control Programme (NACP). This is a structure under the National AIDS Policy (NAP). Its key partners are the Ministry of Health and World Health Organisation (WHO) Global Programme on AIDS (NACP4, 1992). Liaison is made with other governmental and non-governmental organisations in the country. In addition to co-ordinating HIV/AIDS control

programmes, the NACP has these key functions:

- prevention of sexual transmission of HIV through information
- education and communication, control of other STDs
- condom use and counselling and
- epidemiological surveillance and other types of research to facilitate further planning and advocacy for AIDS prevention. In line with the function of HIV prevention the NACP made a recommendation that , AIDS prevention education efforts must not only provide information but also encourage the kind of behaviour change necessary to reverse current trends of HIV infection. The NACP recognized that women are particularly vulnerable to the infection due to their low status in society and early onset of sexual activity.

As one way of implementing NACP's recommendation of changing people's behaviour to counter HIV/AIDS spread, the programme planned workshops for various target groups in the population. A workshop for "Men and AIDS in Botswana" was held in March 1995. A parliamentarian who opened the workshop pointed out the importance of developing strategies and activities that focus on men's responsibility as sexual partners, to prevent HIV transmission especially among women (NACP34, 1995). The difficulty that women meet when attempting to change behaviour within relationships was also cited. Problems such as these were said to be huge barriers to HIV control. Fora like these where men are directly engaged in discussions pertaining to HIV problems, particularly as they affect women, contribute to the control of HIV in childbearing. It is believed that promoting

participation of men in HIV/AIDS prevention activities gives them insight into how their behaviour may negatively affect others and permits them to recommend necessary behaviour change. To achieve this men themselves have to examine gender issues as they influence sexual relationships and reproductive decisions. This analysis must be done in view of associated risks and conscious efforts to change must be made. The AIDS/STD Unit (1998) noted that, studies on men's perceptions address gender related differences and both sexes' ability to negotiate and ensure safer sex practices.

## 2.8 CONCLUSION

The literature reviewed covered HIV/AIDS in childbearing in Botswana in relation to the global situation. It reflected the research achievements in HIV/AIDS in childbearing in Botswana, as well as in other parts of the world. Generally men's perceptions in this , international studies concerning HIV in childbearing have focused on reproductive decision-making. Other research has been directed at preventive strategies which focus on cultural factors to eliminate barriers to behavioural change. In Botswana, some research has been conducted in the areas cited. Both internationally and in Botswana, much of this research has involved women. Although this was a valid starting point, as women were a susceptible group, more work is required on men to compliment findings of studies on women. In this regard, in the past three to four years studies on men's sexuality and their influence on decisions in heterosexual relationships concerning HIV/AIDS have been conducted in Botswana. To date these studies are ongoing.

# CHAPTER 3

## METHODOLOGY

### 3.1 INTRODUCTION

The chapter describes the study design, population and sampling methods, research instrument, validity and reliability, data collection, pilot study, ethical aspects and data analysis.

### 3.2 RESEARCH DESIGN

Data was collected through the use of a survey. The design was appropriate as the study was carried out on a sample of individuals selected from a pre-defined population in their natural setting. The survey design was used because the study is descriptive in nature. The design also permits the use of probability sampling which enhances the generalizability of study findings (Keeves, 1995)

The design was appropriate to elicit men's beliefs' of medical, social and emotional outcomes of co-existence between HIV/AIDS and childbearing. It was an appropriate manner to seek men's beliefs of peoples' responsibilities in decision-making in childbearing concerning HIV/AIDS.

## 3.3 STUDY SETTING

The study was conducted in Somerset West, the only informal settlement in Francistown, Botswana (see Appendix 1). The settlement is located west of the Gaborone-Francistown highway. It is bordered by the Botswana Meat Commission in the South and the Tati river to the North. The railway line forms the western border (see Appendix 2).

## 3.4 POPULATION

The total population of the settlement is 4950. Of these males constitute 2503 (Central Statistics Office (CSO), 1992). Inhabitants of this settlement are literate, semi-literate and illiterate. They are from various cultural backgrounds. The population for the study was all men 18 years and above. From a report of the national population census in 1991, the total number of men in the group in the 18 years + in the settlement was estimated to be 1768 (CSO, 1992).

## 3.5 SAMPLING AND SAMPLE SIZE

### 3.5.1 SELECTION OF HOUSEHOLDS

The total number of households in the settlement was obtained from the Survey's Department. A map (see Appendix 3) of the settlement in which households were identified by numbers (sampling frame) ranging from 20001-20975 was obtained. Systematic sampling with a random start was used to select the required sample size.

The first house number was randomly picked from the sampling frame, then every fourth number was included in the sample until a total of 236 households was obtained. This sample was 39 households over the required sample, to make up for households that did not have men qualifying for inclusion into the sample. According to a statistician's estimates, the required sample size was 11% (197 men) of the total eligible population.

## 3.6 RESEARCH INSTRUMENT

A structured interview schedule (see Appendix 4) was designed. The instrument was written in easily understood English. It was divided into two sections, one for demographic information and the other sought to determine men's knowledge and perceptions of medical, social and emotional effects of HIV/AIDS on childbearing. The second section also described men's opinions of people's responsibilities concerning childbearing decisions in relation to HIV/AIDS. There were a total of 20 questions. Both closed and open ended questions were used. Closed questions sought to establish whether men possessed knowledge or perceptions on variables. Open-ended questions were meant to probe for explanation to the knowledge or perceptions that men had or did not have.

## 3.7 PILOT STUDY

A pilot study was conducted and 5 men were conveniently selected for this purpose. These men did not come from households that had been included in the sample but all

bore qualifying criteria for inclusion into the sample. Following the pilot study alterations were made to question 2 - a "none" category was added. In question 18, all respondents were requested to give an explanation (see Appendix 4). Initially only those who responded positively were asked to give an explanation. No questions needed re-wording following the pilot study, but the researcher gained insight concerning rephrasing of questions when probing responses.

## 3.8 DATA COLLECTION

### 3.8.1 ADMINISTERING THE INTERVIEW SCHEDULE

Data was collected from the second week of July to early August 1998. Data was collected by the researcher herself. Interviews were conducted in the homes of the respondents. A total of 197 men were interviewed. Interviews lasted 15 to 20 minutes. Prior to interviewing anonymity was assured by the researcher and privacy was ensured by sitting in a quiet secluded area. Overhearing by others was limited and women's involvement in the discussions was not allowed. Refusal to take part or withdrawal from participation was clarified, (see Appendix 5). Interviews were conducted between 8:00 hrs and 18:00 hrs everyday. Family welfare educators at Lapologang clinic assisted by providing directions to various areas in the settlement.

## 3.9 VALIDITY AND RELIABILITY

The researcher's supervisor, colleagues and other resource persons were requested to

review the tool. This provided face validity. A pilot study on five respondents in the informal settlement was conducted. The pilot study gave the researcher feedback regarding whether the tool was measuring what it was intended to measure. The pilot study enhanced the content validity of the instrument by ensuring that representative beliefs were included in the instrument (Wilson, 1993 p156). A structured interview schedule was used to standardise the interview. This enhanced the reliability of the instrument. Reliability was further enhanced by the fact that the researcher conducted all the interviews herself.

## 3.10 ETHICAL ASPECTS

In order to proceed with the study:

3.10.1 Permission was obtained from the Committee for Research on Human Subjects (medical), University of the Witwatersrand, Johannesburg - protocol number M980531 (see Appendix 6).

3.10.2 Permission was also obtained from the Office of the President, Botswana Government (see Appendix 7).

3.10.3 Verbal consent was obtained from all respondents.

3.10.4 All respondents were assured of confidentiality, anonymity and the option to withdraw from the interview (see Appendix 5).

## 3.11 DATA ANALYSIS

Data was analysed using the Epi Info Version 6 Statistical Package. This package is normally used to process health related information. It is capable of simple data analysis as well as cross-tabulating information. Statistical tests can also be performed with the package in order to establish significance of relationships between variables. Data was analysed in two parts. Part A includes simple descriptive analysis whereas part B employed the use of the Chi-square ($x^2$) to establish any association between variables.

## 3.12 CONCLUSION

In this chapter the methods and procedures for achieving the purpose of the study have been laid out.

The study setting, population and the sampling have been described. The research instrument and data collection procedures have been explained. Ethical considerations have been identified and the method of data analysis has been outlined.

In the following chapter the research findings will be presented.

# CHAPTER 4

## FINDINGS AND DISCUSSION OF FINDINGS

### 4.1 INTRODUCTION

Findings will be discussed in two parts - A and B. Part A will include demographics, and men's perceptions of medical, emotional and social effects of HIV/AIDS in childbearing. Findings on perceptions of responsibilities concerning decision-making and childbearing in relation to HIV/AIDs will be included. In part B analysis of bivariate data using the chi-square ($x^2$) will be presented. This section will attempt to illustrate any association emerging between demographic information and responses to various questions. In both parts graphic illustrations such as frequency distributions, bar charts, pie charts and histograms will be used.

PART A

### 4.2 DEMOGRAPHIC INFORMATION

#### 4.2.1 AGE

Age groups that respondents fell into are illustrated in table 4.1.

Table 4.1 **RESPONDENTS' AGE GROUPS (n=197)**

| AGE GROUP | FREQUENCY | PERCENTAGE |
|---|---|---|
| 18-20 | 28 | 14.2 |
| 21-25 | 33 | 16.8 |
| 26-30 | 39 | 19.8 |
| 31-35 | 14 | 7.1 |
| 36-40 | 21 | 10.7 |
| 41-45 | 21 | 10.7 |
| 46-50 | 10 | 5.1 |
| 51-55 | 6 | 3.0 |
| 56-60 | 10 | 5.1 |
| 61+ | 15 | 7.6 |
| Total | 197 | 100.0 |

The largest group of respondents, 19.8% (n=197) were aged between 26-30 years. The least represented age group was the 51-55 years. The majority, 100 (50.8%), of the respondents were between the ages 18-30 years. This finding is consistent with the findings of the 1991 census (Central Statistics Office, 1992) portraying a population structure in Botswana whereby 43% of the population constitutes people within the ages 15-49 years. Therefore a large group of the population is likely to be at higher risk of contracting infection as they are more likely to engage in sexual activity than other age groups. Educational programmes to accommodate the needs of a younger population in the prevention of HIV infection must be put in place.

### 4.2.2 EDUCATIONAL LEVEL

The histogram shows the educational level of respondents (see figure 4.1)

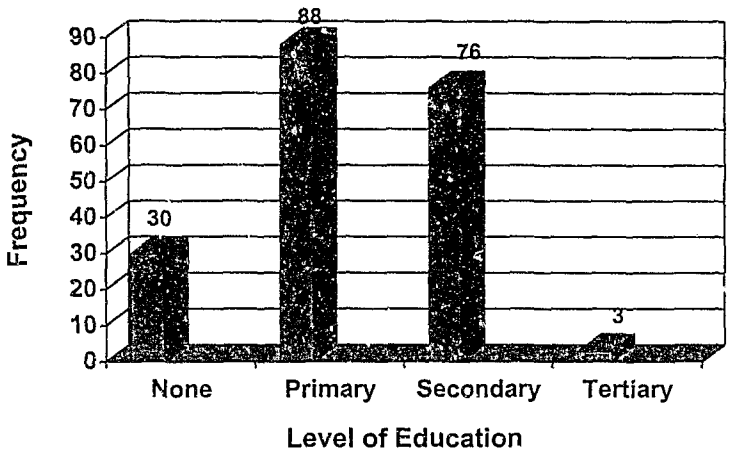



FIGURE 4.1 EDUCATIONAL LEVEL OF RESPONDENTS (n=197)

The most represented educational level was primary education accounting for 88 ( 44.7%) of the respondents. Only three (1.5%) respondents had tertiary education. Thirty (15.2%) had no form of education at all. This has implications for the content and structure of HIV/AIDS educational programmes for this community.

### 4.2.3 MARITAL STATUS

Table 4.2 depicts the relationships respondents were involved in at the time of the data collection.

TABLE 4.2 DISTRIBUTION OF RESPONDENTS BY MARITAL STATUS (n=197)

| MARITAL STATUS | FREQUENCY | PERCENTAGE |
|---|---|---|
| Cohabiting | 57 | 28.9 |
| Divorced | 3 | 1.5 |
| Married | 65 | 33.0 |
| Single | 66 | 33.5 |
| Widowed | 6 | 3.0 |
| Total | 197 | 100.0 |

Sixty six (33.5%) of the 197 respondents were single. There was a further group of 57 (28.9%), who were cohabiting. This brought to 62.4%, the group of respondents who functioned within relationships which may have less commitment. If sexually active they may stand a higher risk for contracting infection than their married counterparts. Instances like these which suggest increased vulnerability to infection need to be taken into account when planning preventive strategies.

### 4.2.4 OCCUPATION

Figure 4.2 is a representation of the occupational status of the respondents.

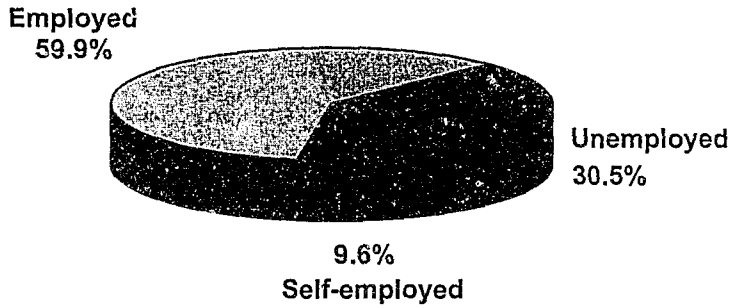



FIGURE 4.2 RESPONDENTS' OCCUPATIONAL STATUS (n=197)

The majority, 118 (59.9%) of the respondents were employed. This figure can be increased to 137(69.5%) when one considers that 19 (9.6%) of the respondents were self employed. In spite of the large employment figures, it is possible that most of these occupations are poorly paid. Observation of health indicators among various communities worldwide (spread of communicable diseases being one of them), has shown a strong negative association between health and poverty (Green, 1994). As with other communicable diseases, the spread of HIV infection in this settlement may be aggravated by this factor.

### 4.2.5 RELIGION

The religious affiliations of respondents are shown in table 4.3

TABLE 4.3 **RELIGIOUS AFFILIATIONS OF RESPONDENTS (n=197)**

| RELIGION | FREQUENCY | PERCENTAGE |
|---|---|---|
| Christian | 134 | 68.0 |
| Traditional belief | 38 | 19.3 |
| Other | 5 | 2.5 |
| None | 20 | 10.2 |
| Total | 197 | 100.0 |

One hundred and thirty four (68.0%) of the respondents were Christians. An additional 38 (19.3%) of the respondents practised a form of religious belief, that was traditional in nature Traditional belief means believing in gods. There were no Muslims and Hindus. The five men who have been categorized under "other" stated that they believed in some form of supernatural being, but they did not have any forms of religious practice. Religion as a form of culture results in specific beliefs in those who adhere to it and is therefore likely to influence perceptions and behaviour. It may be important to incorporate religious ideas in HIV prevention programmes where possible. Alternatively religious organisations may be involved in preventive strategies.

### 4.2.6 ETHNICITY

Respondents came from 25 ethnic groups. This may be attributed to the nature of the settlement and its location. However, four ethnic groups were most represented and table 4.4 illustrates these. These four accounted for 64.9% of the 197 respondents.

TABLE 4.4 THE MOST REPRESENTED ETHNIC GROUPS (n=128)

| ETHNIC GROUP | FREQUENCY | PERCENTAGE |
|---|---|---|
| Mokalaka | 82 | 64.0 |
| Mongwato | 18 | 14.1 |
| Morotse | 11 | 8.6 |
| Motswapong | 17 | 13.3 |
| Total | 128 | 100.0 |

The majority 82(64.0%) were of Kalanga (Mokalaka) origin. This may be attributed to the fact that the city of Francistown is situated in the North-Eastern part of the country, which is predominantly a Kalanga area. The other ethnic groups shown in the table originate in areas relatively near the city.

## 4.3 KNOWLEDGE

This section was meant to determine the knowledge that men had on HIV/AIDS. They were required to indicate with a yes or no answer whether they had heard about HIV and AIDS before. If their answer was yes, they were asked to give an explanation.

### 4.3.1 HAVE YOU HEARD ABOUT HIV/AIDS?

Almost all, 99%, (n=195) of the respondents reported having heard about HIV/AIDS. Only two men had not heard about HIV/AIDS.

### 4.3.2 MEN'S KNOWLEDGE ON HIV/AIDS

This was an open-ended question and the responses could be categorised into could not

explain, (although they had heard the names HIV/AIDS, they did not know what they meant; description; description and transmission; description, transmission and prevention; description, transmission and signs and symptoms and description, transmission, signs and symptoms; and prevention. Table 4.5 presents men's knowledge on HIV/AIDs according to these categories.

TABLE 4.5 **MEN'S KNOWLEDGE ON HIV/AIDS (n=195)**

| KNOWLEDGE | FREQUENCY | PERCENTAGE |
|---|---|---|
| Could not explain | 4 | 2.1 |
| Description | 15 | 7.7 |
| Description and transmission | 21 | 10.8 |
| Description, transmission and prevention | 55 | 28.2 |
| Description, transmission and, signs and symptoms | 4 | 2.1 |
| Description, transmission, signs and symptoms and prevention. | 96 | 49.2 |
| Total | 195 | 100.0 |

Ninety six (49.2%) of the 195 respondents who had given a positive answer were able to describe HIV/AIDS and state its transmission, signs and symptoms and prevention. A further 55 (28.2%) of the respondents could give its description, transmission and prevention.

With reference to table 4.5 it may appear that all the respondents were knowledgeable about HIV/AIDS. However, a few did not have accurate information. Rather, they reflected misconceptions. However all responses were fitted into the given categories for example, description, irrespective of whether they were correct. For example a

respondent said, "AIDS is transmitted by sleeping with an aborted woman. Signs and symptoms include swelling of legs and the stomach and penile sores". Another reported, "I believe this sexually transmitted disease is "sekadzi" which affects kidneys and causes sores in the anal and penile areas". Despite this observation 193 (99%) of the 195 men had sound scientific knowledge. Loss of weight, diarrhoea and cough were mentioned by more than 50% as manifestations of AIDS. These findings demonstrate that most respondents had substantial factual information on HIV/AIDS. It would appear therefore, that if risky behaviours are practised, it is not because of lack of information on the condition.

## 4.4 PERCEPTIONS OF MEDICAL EFFECTS OF HIV/AIDS ON CHILDBEARING

### 4.4.1 EFFECTS OF HIV/AIDS ON CHILDBEARING

Men's perceptions of the effects of HIV/AIDS on childbearing appear in the categories shown in table 4.6.

TABLE 4.6 EFFECTS OF HIV/AIDS ON CHILDBEARING (n=197)

| EFFECTS OF HIV/AIDS | FREQUENCY | PERCENTAGE |
|---|---|---|
| No knowledge | 80 | 40.6 |
| No effect | 2 | 1.0 |
| Pregnancy complications | 1 | 0.5 |
| Maternal ill health | 13 | 6.6 |
| Vertical transmission | 73 | 37.1 |
| Maternal ill health and vertical transmission | 25 | 12.7 |
| Vertical transmission and pregnancy complications | 2 | 1.0 |
| Maternal ill health, vertical transmission and pregnancy complications | 1 | 0.5 |
| Total | 197 | 100.0 |

Of 197 respondents, 80 (40.6%) stated that they did not know how HIV/AIDS affects childbearing. Seventy three (37.1%) mentioned vertical transmission as an effect, while an additional 28 (14.2%) mentioned vertical transmission as well as other effects. This brings to 101 (51.3%) the number of those who gave vertical transmission as an effect of HIV/AIDS on childbearing. Only one (0.5%) man was able to give the three aspects of the medical effects, i.e. maternal ill health, vertical transmission and pregnancy complications.

The findings therefore indicate that the majority, 196 (99.5%), lack a complete understanding of HIV/AIDS and its effects on childbearing as they were not aware of all the effects. As vertical transmission was mentioned by the majority (50.8%) of the respondents, it can be assumed that it would enable them to engage in serious decision making prior to having a child. Educational programmes could be geared at channelling their influence positively to deter their partners from having children when it is not safe

least to observe available precautions. Mention of other effects including maternal ill health and pregnancy complications by fewer respondents may be an illustration of lack of knowledge of the wider effects of HIV/AIDS on childbearing. This deficit may be a result of men's lack of experiential learning which women are exposed to in childbirth matters. This indicates a need to provide more than basic facts in health education. In addition, a need exists to consider gender differences in delivering health education.

### 4.4.2 EFFECTS ON CHILDBEARING ON HIV/AIDS

Table 4.7 below depicts men's perceptions of the effects of childbearing on HIV/AIDS

TABLE 4.7 **MEN'S PERCEPTIONS OF THE EFFECT OF CHILDBEARING ON HIV/AIDS (n = 197)**

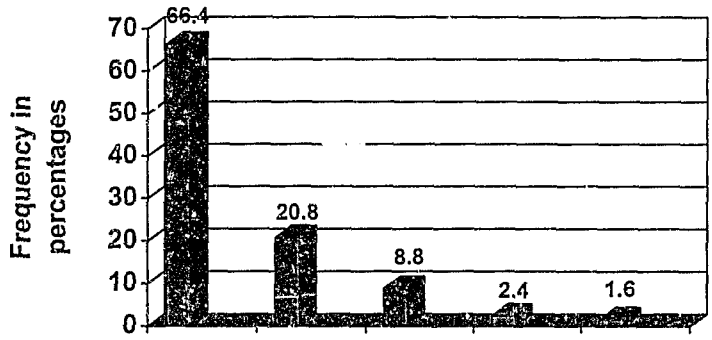
| EFFECT OF CHILDBEARING | FREQUENCY | PERCENTAGE |
|---|---|---|
| Does not know | 73 | 37.1 |
| No effect | 8 | 4.1 |
| Aggravates HIV/AIDS | 115 | 58.4 |
| Improves HIV/AIDS | 1 | 0.5 |
| Total | 197 | 100.0 |

The majority of the respondents, 115 (58.4%), were aware that childbearing is likely to worsen an HIV/AIDS status, while 73 (37.1%) did not know the effects of childbearing on HIV/AIDS. The latter group bears evidence to the fact that there is still a lack of knowledge about HIV/AIDS issues despite educational campaigns countrywide. Lower levels of education may contribute to restricted understanding of these issues by respondents.

## 4.5 PERCEPTIONS OF EMOTIONAL EFFECTS OF HIV/AIDS ON CHILDBEARING

### 4.5.1 EMOTIONAL/MENTAL EFFECTS OF HIV/AIDS IN CHILDBEARING ON WOMEN

Of 197 respondents, the majority, 125 (63.5%) said that HIV/AIDS emotionally affects women, while 72 (36.5%) felt that the condition has no emotional effect on women. Of those who responded positively, emotional effects were described as illustrated in the diagram below (see figure 4.3).




Key: 66.4% = Death (disease outcome)
20.8% = Death (disease outcome), ill health and care, welfare of dependants
8.8% = Complications of pregnancy e.g. abortion
2.4% = Welfare of dependants
1.6% = Stigmatization and marital conflicts

**FIGURE 4.3 EMOTIONAL CONCERNS OF WOMEN REGARDING HIV/AIDS (n=125)**

Of the 125 respondents who gave a positive answer to this question, the majority, 109 (87.2%), were concerned with death (disease outcome) of the mother, unborn baby or both. Eleven respondents (8.8%) mentioned pregnancy complications as women's concern for HIV/AIDS in childbearing. Four percent of the respondents could only perceive personal types of concerns of HIV/AIDS in childbearing, such as welfare of dependants, stigmatization and marital conflicts.

It would appear that the ultimate prognosis of HIV/AIDS is well known, but the reality of what takes place prior to death appears to be underestimated. To emphasize some of these effects, education must be geared towards developing people's insight into the multi-dimensional problems associated with HIV/AIDS in childbearing. This would enhance appreciation of the emotional burden that HIV/AIDS in childbearing places upon people, particularly on women as the child bearers.

### 4.5.2 EMOTIONAL/MENTAL EFFECTS OF HIV/AIDS ON MEN

Of 197 respondents, 158 (80.2%) believed that HIV/AIDS affects men emotionally. The remaining 39 (19.8%) felt that men are not emotionally affected by HIV/AIDS. The descriptions of men's emotional concerns as stated by those who gave a positive response are illustrated in table 4.8.

TABLE 4.8 MEN'S EMOTIONAL CONCERNS OF HIV/AIDS IN CHILDBEARING (n=158)

| EMOTIONAL CONCERN | FREQUENCY | PERCENTAGE |
|---|---|---|
| Death (disease outcome) | 83 | 52.5 |
| Contracting infection | 37 | 23.4 |
| Ill health, care of ill mother | 17 | 10.8 |
| Vertical transmission | 16 | 10.1 |
| Marital conflicts | 1 | 0.6 |
| Marital instability | 1 | 0.6 |
| Death (disease outcome) welfare of dependants | 1 | 0.6 |
| Aggravation of HIV/AIDS | 1 | 0.6 |
| Guilt | 1 | 0.6 |
| Total | 158 | 100.0 |

The majority, 84 (53.1%), of the respondents believed that men would be concerned about death. The finding is similar to that concerning women's emotional effects of HIV/AIDS. Thirty seven (23.4%) respondents were concerned about contracting infection.

Responses to this question were similar to those in the previous one about women's emotional concerns, except for contacting infection, mental instability and guilt feelings. Death (disease outcome) still featured as the major concern, probably because it is the ultimate reality about HIV/AIDS that people have to face. The other factor could be that public education emphasises death as the final outcome of HIV/AIDS. Although it is important for people to realise that HIV/AIDS ultimately results in death, they also need to understand the full impact of the condition prior to death.

### 4.5.3 EMOTIONAL/MENTAL EFFECTS OF HIV/AIDS ON OTHERS

Of the 197 respondents, the majority of the respondents, 161 (81.7%), felt that besides women and men there are others who are emotionally affected by HIV/AIDS in childbearing. The remaining 36 (18.3%) respondents indicated that no others would be affected. Others who were mentioned as being affected are reflected in table 4.9 below.

TABLE 4.9 **OTHERS WHO ARE EMOTIONALLY AFFECTED BY HIV/AIDS IN CHILDBEARING (n=161)**

| OTHER | FREQUENCY | PERCENTAGE |
|---|---|---|
| Children | 3 | 1.9 |
| Friends | 1 | 0.6 |
| Government | 1 | 0.6 |
| Health personnel | 2 | 1.2 |
| Previous sexual partner | 1 | 0.6 |
| Relatives | 146 | 90.7 |
| Relatives and children | 1 | 0.6 |
| Relatives and friends | 6 | 3.7 |
| Total | 161 | 100.0 |

A total of 153 (95.0%) respondents reported relatives as others who could be emotionally affected by HIV/AIDS. Children were mentioned by four (2.5%) of the respondents as others who could be affected and it is not clear whether they were implied by those who mentioned relatives. One would assume that as closer relations to their parents they would have been mentioned more than other groups of those who could be affected.

Relatives were identified by the largest group of respondents as others who could be emotionally affected by HIV/AIDS in childbearing. With the extended family structure

in Botswana, relatives range from close to very distant relations. People usually feel obliged by these relational ties and are often compelled to offer support when there is need, for example by caring for the sick. It is good that relatives may be concerned about another sick relation. However, if the concern leads to them caring for that relation it may result in spread of infection if they do not have adequate information on care principles regarding the condition, for example preventing cross-infection. Health education thus needs to be provided on care of an HIV/AIDS patient and precautions where the diagnosis is not known.

Respondents who said that there are others who could be emotionally affected by HIV/AIDS went on to describe the various ways in which these others would be affected (see table 4.10 page 60).

The majority, 138 (85.7%), of the respondents indicated death to be the concern of others. Of these, 39 (24.2%) mentioned welfare of dependants on the loss of the guardian (parent). It is important to note that death was yet again overwhelmingly mentioned as a concern to others following the trend that has emerged in previous questions (see tables 4.3 and 4.8).

TABLE 4.10 EMOTIONAL CONCERNS OF OTHERS FROM HIV/AIDS IN CHILDBEARING (n=161)

| EMOTIONAL CONCERN OF OTHER | FREQUENCY | PERCENTAGE |
|---|---|---|
| Death (disease outcome) | 99 | 61.5 |
| Caring for ill relative | 14 | 8.7 |
| Death (disease outcome) and welfare of dependants | 39 | 24.2 |
| Pregnancy complications and infection transmission | 3 | 1.9 |
| Aggravation of HIV/AIDS | 1 | 0.6 |
| Conflicts | 3 | 1.9 |
| Stigmatization | 2 | 1.2 |
| Total | 161 | 100.0 |

### 4.5.4 EMOTIONAL/MENTAL EFFECTS OF HIV/AIDS IN CHILDBEARING ON THE COMMUNITY/SOCIETY

The emotional effects of HIV/AIDS in childbearing on the community are shown in table 4.11

TABLE 4.11 EMOTIONAL EFFECTS OF HIV/AIDS IN CHILDBEARING ON THE COMMUNITY/SOCIETY (n=197)

| EFFECT ON COMMUNITY | FREQUENCY | PERCENTAGE |
|---|---|---|
| Emotional stress | 16 | 8.1 |
| Conflicts | 8 | 4.1 |
| Suicide | 16 | 8.1 |
| Stigma | 3 | 1.5 |
| Suicide, Stigma and Conflicts | 4 | 2.0 |
| Mental illness | 2 | 1.0 |
| Conflicts and baby dumping | 2 | 1.0 |
| None | 146 | 74.1 |
| Total | 197 | 100.0 |

The majority of the respondents, 74.1% (n = 197), reported that HIV/AIDS in childbearing does not have any emotional effects on the community. Sixteen (8.1%) respondents felt that HIV/AIDS results in emotional stress and the same number stated suicide as an emotional effect. It is not apparent why the majority of the respondents felt HIV/AIDS does not emotionally affect the community, when in previous questions they reported that it has effects on women, men and others. It may be possible that most of the respondents who gave this answer failed to make inferences from specific situations to perceive the wider effects of HIV/AIDS. Another factor that may be linked to this lack of perception is that though some emotionally related problems occur in communities arising from HIV/AIDS, the confidentiality surrounding the condition makes it impossible for people to make any association between the two. This factor encourages denial of the existence of HIV/AIDS as it is often perceived rather as a conceptual phenomenon than reality. It is important therefore that in educational fora, discussion of issues pertaining to HIV/AIDS should be encouraged to accord the public insight, beyond the bare facts.

The minority who could perceive some emotional effects of HIV/AIDS in childbearing on the community, mentioned emotional stress and other associated problems as community's concerns. Problems such as concerns for suicide, conflicts in relationships, mental illness, social stigmatization and baby dumping are suggested by the study to be associated with HIV/AIDS. This finding is consistent with the literature about HIV/AIDS problems in Botswana (AIDS/STD Unit, 1998). A need exists to make people aware of these problems and seek appropriate ways of dealing with them.

## 4.6 PERCEPTIONS OF SOCIAL EFFECTS OF HIV/AIDS IN CHILDBEARING

### 4.6.1 SOCIAL EFFECTS OF HIV/AIDS IN CHILDBEARING

Of the 197 respondents, 157 (79.7%) believed that HIV/AIDS in childbearing affects the society. The remainder, 40 (20.3%) stated that HIV/AIDS does not affect society. The table below illustrates societal effects of HIV/AIDS as described by respondents who gave a positive answer.

Table 4.12 SOCIAL EFFECTS OF HIV/AIDS IN CHILDBEARING (n=157)

| SOCIAL EFFECTS OF HIV/AIDS | FREQUENCY | PERCENTAGE |
|---|---|---|
| Many deaths | 82 | 52.2 |
| Many deaths and orphans | 13 | 8.3 |
| Many deaths, labour loss, and economic depression | 19 | 12.1 |
| Care costs, economic depression | 7 | 4.5 |
| Infection transmission | 26 | 16.6 |
| Many deaths, orphans, labour loss, economic depression | 7 | 4.5 |
| Conflicts | 3 | 1.9 |
| Total | 157 | 100.0 |

Among those who had indicated that HIV/AIDS in childbearing has some social effects, 121 (77.1%) reported that loss of lives is the greatest social effect. Twenty six (16.6%) mentioned infection transmission as one effect of HIV/AIDS on the society. A total of 33 (21.1%) respondents felt that HIV/AIDS problems ultimately result in economic problems. Responses to this question still signify that respondents view death as the major concern for people regarding HIV/AIDS. However, although fewer, 53 (33.8%) respondents did recognise other social concerns about HIV/AIDS such as increase in

health care costs, orphans, labour loss and economic depression.

In conjunction with consolidation of other aspects in educational programmes, facts about death could be given with the hope that people's behaviour would be modified. However, it must be ensured that rhetorical talk about death from AIDS is avoided.

A variety of other social problems arising from HIV/AIDS were mentioned, including economic losses through costs incurred from caring for HIV/AIDS patients, loss of labour force resulting in reduced productivity, care for orphans and efforts to control infection. All these perceptions are in line with what national authorities perceive as social problems imposed by HIV/AIDS in Botswana (NACP4, 1992). Understanding of these by the whole population may reflect the impact of HIV/AIDS and may assist people to relate the condition to their own personal lives and hence to take steps to prevent it.

### 4.6.2 THE EXTENT OF PROBLEMS IMPOSED BY HIV/AIDS IN CHILDBEARING ON SOCIETY

The respondents were asked to express their feelings about the extent of problems imposed on the society by HIV/AIDS. This question was only posed to those who had earlier indicated that HIV/AIDS affects society.

Of 157 respondents, 156 (99.4%) believed there are social problems caused by HIV/AIDS in childbearing. Only one respondent felt that such problems are insignificant. It appears appropriate that the majority of the respondents perceive

HIV/AIDs related social problems, since the majority were able to site effects of HIV/AIDS on various groups of people in society as well as the general social effects. As previously noted, this demands changes in public educational approaches.

## 4.7 PERCEPTIONS OF MEN REGARDING RESPONSIBILITIES CONCERNING DECISION MAKING AND CHILDBEARING IN RELATION TO HIV/AIDS

### 4.7.1 CONTROL IN CHILDBEARING DECISIONS

The respondents were asked to indicate who they felt had more control in childbearing decisions between men, women and others. Some respondents gave more than one response (see table 4.13).

**TABLE 4.13 CONTROL IN CHILDBEARING DECISIONS** (n=197)

| DECISION CONTROLLER | FREQUENCY | PERCENTAGE |
|---|---|---|
| Do not know | 1 | 0.5 |
| Men | 114 | 57.9 |
| Men and women | 55 | 27.9 |
| Women | 27 | 13.7 |
| Others | | |
| Total | 197 | 100.0 |

One hundred and fourteen respondents (57.9%) out of the 197, said men have more control in childbearing decisions. The second largest number of respondents, 55 (27.9%) indicated that men and women have an equal say in childbearing decisions. An interesting factor to note is that, men did not think of any other strong influences in childbearing decisions, like in-laws and parents, in spite of what influence they are

accorded by the traditional Tswana culture in family matters. Their role in the extended family structure wields substantial power over these decisions as they are viewed as overall advisors in extended families under them.

Earlier findings in the study showed that some men did not know how childbearing affects HIV/AIDS and vice versa. In light of this, if men exert control in childbearing decisions there is a likelihood of an increase in infection rates.

An additional interesting observation is that women were mentioned as decision controllers by a substantial number (41.6%).

### 4.7.2 VIEWPOINTS ON CONTROL IN CHILDBEARING DECISIONS

As a follow up of the previous question (see 4.7.1), the respondents were asked to indicate using, yes or no, whether the person they had indicated as being in control of childbearing decisions was rightfully so. Subsequently another part of this question asked the respondents to explain their response.

Six (3.0%) respondents reported that although they feel men are in control of childbearing decisions, the practice is not proper. The majority of the respondents, 190 (96.9%) believed that whoever, they had indicated to be in control of childbearing decisions is rightfully so. One respondent who had previously give a "do not know" response did not answer this part of the question and could not explain his answer. Table 4.14 illustrates the view points given by respondents regarding who controls decision-making in childbearing.

TABLE 4.14 JUSTIFICATION OF VIEW POINTS ON CONTROL OF CHILDBEARING DECISIONS (n=196)

| REASON FOR CONTROL | FREQUENCY | PERCENTAGE |
|---|---|---|
| Women as childbearers control decisions | 28 | 14.3 |
| Men as heads of the family control decisions | 108 | 55.1 |
| Decisions are a joint affair between men and women | 60 | 30.6 |
| Total | 196 | 100.0 |

Of 196 respondents, 108 (55.1%) argued that the man as head of the family controls childbearing decisions, as dictated by culture. Men who stated the existence of equal control in childbearing decisions between men and women felt that childbearing is a joint affair between the two parties and is thus controlled by both. For the same reason, the six respondents (3.0%) who had indicated that men control childbearing decisions did not think that this is proper. Twenty-eight (28) men believed that women as child bearers control these decisions. One respondent said it is easier for a woman to have a child without a man's consent than the reverse. He stated "It is not very difficult for a woman to fall pregnant, even if the man does not want her to. So women control these decisions". Another said, "Often men and women do not sit down to decide the number of children they want to have, but the woman continues to bear children until she feels they are enough, then she stops". It was also reflected that sometimes women have children against men's wishes to commit the man to a failing relationship. To this effect one man said, "To stop a man from leaving, a woman may deliberately fall pregnant". The ideal situation is for both partners to be involved in childbearing decisions and to consider all the necessary responsibilities. This may assist in the prevention of HIV

transmission.

## 4.8 RESPONSIBILITIES REGARDING DECISION MAKING IN CHILDBEARING

Of 197 respondents, a majority of 178 (90.4%) felt there are responsibilities regarding childbearing decision-making whereas 19 (9.6%) felt that there are no responsibilities to consider when making these decisions. Table 4.15 illustrates explanations of those who offered a positive response.

TABLE 4.15 PERCEPTIONS OF RESPONSIBILITIES TO CONSIDER REGARDING DECISION-MAKING IN CHILDBEARING

(n=178)

| RESPONSIBILITY | FREQUENCY | PERCENTAGE |
|---|---|---|
| Support | 112 | 62.9 |
| Continuing the family name | 31 | 17.4 |
| Health status and family name | 19 | 10.7 |
| Health status and support | 15 | 8.4 |
| Compliance with the bible | 1 | 0.6 |
| Total | 178 | 100.0 |

One hundred and twenty seven (71.3%) of 178 respondents indicated support of their children as a responsibility to consider in making childbearing decisions. A total of 50 (28.1%) reported that these decisions are made with a view to meeting the responsibility of carrying on the family name. Interestingly, 34 men (19.1%) felt that the responsibility of considering the health status of the involved parties in making these decisions.

Lack of consideration of the health status of partners involved in childbearing is likely to impact negatively on HIV transmission and outcome. It also appears that childbearing decisions are ingrained in cultural beliefs. One respondent said, "Every man will want a boy in his family, if this does not happen he will urge his wife to continue trying until a boy is born, no matter what. Sometimes a man will send a woman back to her parents for not giving him a boy". This situation is detrimental to health and obviously has negative implications for HIV/AIDS. Formulation of culture specific approaches to public education are thus imperative.

## 4.9 CULTURAL INFLUENCE ON CHILDBEARING DECISIONS

Of the 197 respondents, 95 (48.2%) could perceive a cultural influence on childbearing decisions and 102 (51.8%) felt that culture does not influence the decisions. These responses are contradictory to those previously made in relation to culture (see 4.7.2). It would appear that some responses were based on what men would like to see happening, rather than on reality and hence the discrepancy.

Table 4.16 depicts respondents' explanations of cultural influence on decision-making in childbearing matters.

TABLE 4.16 CULTURAL INFLUENCE ON CHILDBEARING DECISIONS

(n=95)

| CULTURE INFLUENCE | FREQUENCY | PERCENTAGE |
|---|---|---|
| Cultural expectation to bear children | 71 | 74.7 |
| Can not explain influence | 24 | 25.3 |
| Total | 95 | 100.0 |

The majority, 71 (74.7%), of the respondents who gave a positive response explained that it is a cultural expectation for every couple to bear children. Responses in this category included statements such as: "What is a relationship without a child. Culture expects a marriage to result in children". According to the Setswana culture a man and a woman living together must have a child, otherwise the relationship is meaningless. Despite indicating that culture has an influence on decision-making, 24 (25.3%) were unable to support their answer and stated that they could not explain cultural influence. This observation could explain the discrepancy noted earlier in this question and may imply that though most respondents were aware of cultural influence on childbearing decisions they could not eloquently explain in what manner. The cultural belief dictating couples to have children bears negative connotations for control of HIV/AIDS, if not viewed in relation to other factors. It is very closely linked to the idea of carrying on a family name, mentioned earlier, which could equally be hazardous in relation to HIV/AIDS in childbearing. This further points to an existence of a need to restructure educational approaches appropriately to address cultural barriers in control of HIV/AIDS.

## 4.10 ANY OTHER INFORMATION ON HIV/AIDS IN CHILDBEARING

Of 197 respondents, 50 (25.4%), made suggestions pertaining to control of HIV/AIDS. Twenty nine (14.7%) raised questions about HIV/AIDS.

The suggestions mostly called for government's interventions in restoring cultural order by eliminating situations that disrupt such order. Some of the suggestions related to:

- Reduction in the number of liquor outlets (bars, bottle stores, discos).
- Formulation of stringent regulation for the operation of public places.
- Proper monitoring of students in schools, avoiding giving sexual information to young children as in schools and on television.
- Permitting polygamy.

Liquor outlets were revealed to be the initial contact places for spread of HIV as youth frequent these for entertainment, ultimately ending up being drunk and hence engaging in risky behaviour. Supervision and monitoring of pupils, particularly in boarding schools, was thought to be relaxed leading to youth indulging in sexual activity and the spread of HIV. One respondent said, "look at all the teenage pregnancies and the noise about sex in schools. How can we prevent AIDS? Rules in schools must be stricter and the government must do something about this". Provision of sexual information to young children was seen as inciting their sexual interest and implying to them that sexual activity is not wrong. One man retorted, "sex used to be taboo, now it does not seem like a prohibited area because it is talked about so lightly. The government wants our

children to be taught sex very early. For the situation to change government must come in". Polygamy was also suggested as a way of controlling HIV/AIDS. The explanation was that since there are more women than men, it would enable every woman to have a stable partner, preventing changing of partners. Implications were made that polygamy would assist in quenching men's desire for many women, as each would legally have several of them permanently. In view of all these, it is not difficult to acknowledge the complexity of educating the public about HIV control. Successful approaches towards meeting this aim would need to address all these issues appropriately.

Questions asked related to basic information on HIV/AIDS, for example cause, signs and symptoms, difference between HIV and AIDS, and treatment. Other respondents wanted to know whether the lubricant in condoms caused HIV. Also, much interest was shown regarding implementation plans on completion of the study. This indicates society's eagerness to obtain solutions to HIV/AIDS problems. Despite educational attempts to inform people about HIV/AIDS, a need still exists to fill gaps in terms of knowledge and misconceptions. The following diagram illustrates responses regarding any other information on HIV/AIDS in childbearing (see figure 4.5).

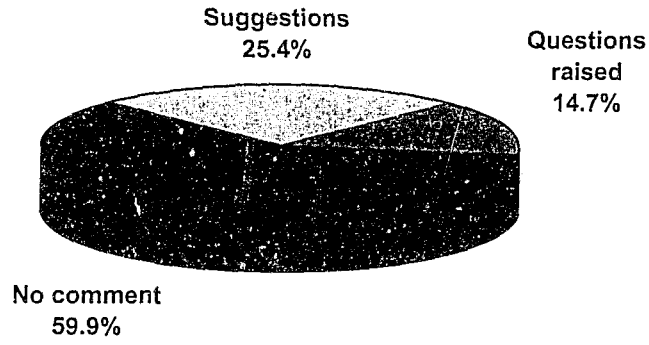



FIGURE 4.5 ADDITIONAL INFORMATION ON HIV/AIDS IN CHILDBEARING (n=197)

## PART B

This part presents analysis of bivariate data. The chi-square was applied to demonstrate relationships existing between variables. Demographic variables were analysed against variables on men's perceptions. This analysis is shown in table 4.17 on page 63. The level of significance is set at $p \geq 0.05$.

### 4.11 EMOTIONAL EFFECTS OF HIV/AIDS ON WOMEN AND AGE

There was a strong association between age and the responses on emotional effects on women from HIV/AIDS in childbearing. It is not apparent why age and men's perceptions of whether women have emotional concerns were related, but the findings showed that the majority of men 84% (n=197) gave a positive response and were mostly in the age groups between 18-20 and 41-45 years.

## 4.12 RELIGION AND CONTROL OF CHILDBEARING DECISIONS

A statistically significant relationship between religion and men's perceptions of control of childbearing decisions was demonstrated. It is not apparent why this relationship occurred but it may be a reflection of the association which is generally made by people between issues of existence and religion.

Table 4.17 DEMOGRAPHIC INFORMATION AGAINST VARIABLES ON MEN'S PERCEPTIONS

| VARIABLES ON MEN'S PERCEPTIONS | P VALUE | | | | |
|---|---|---|---|---|---|
| | AGE | Education | Marital Status | Occupation | Religion |
| Knowledge about HIV/AIDS | 0.10 | 0.49 | 0.46 | 0.09 | 0.71 |
| Effects of HIV/AIDS on childbearing | 0.20 | 0.40 | 0.96 | 0.19 | 0.51 |
| Effects of childbearing on HIV/AIDS | 0.20 | 0.15 | 0.23 | 0.09 | 0.50 |
| Emotional effects of HIV/AIDS in childbearing on women | *0.01 | 0.51 | 0.08 | 0.82 | 0.09 |
| Emotional effects of HIV/AIDS in childbearing on men | 0.45 | 0.07 | 0.07 | 0.09 | 0.23 |
| Others emotionally affected by HIV/AIDS in childbearing | 0.21 | 0.06 | 0.60 | 0.21 | 0.30 |
| Emotional effects of HIV/AIDS in childbearing on the society | 0.00 | 0.32 | 0.06 | 0.70 | 0.52 |
| How extent of problems imposed by HIV/AIDS in childbearing on society | 0.09 | 0.81 | 0.08 | 0.26 | 0.95 |
| Control of childbearing decisions | 0.53 | 0.23 | 0.48 | 0.82 | *0.01 |
| Justification of viewpoints on control of childbearing decisions | 0.31 | 0.74 | 0.06 | 0.22 | 0.86 |
| Responsibilities regarding decision making in childbearing | 0.09 | 0.44 | 0.37 | 0.60 | 0.75 |
| Cultural influence on childbearing decisions | 0.12 | 0.59 | 0.75 | 0.39 | 0.27 |
| Other information | 0.14 | 0.87 | 0.23 | 0.93 | 0.49 |

* Significant values.

## 4.13 CONCLUSION

In this chapter the findings of the study were presented and discussed. The chapter was divided into two parts. Part A presented findings of the variables under study and part B addressed analysis of bivariate data using the chi-square ($x^2$). The study suggested that the majority (98.0%) of the interviewed men have some knowledge on HIV/AIDS. Men associated HIV/AIDS with various physical effects, especially death and emotional stresses on different people. Further, the findings of the study revealed that men relate emotional stress with concern about death of those affected. In addition, men could perceive the social implications of HIV/AIDS in childbearing. Cultural issues were demonstrated to exert an influence in childbearing decisions.

# CHAPTER 5

# SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

This chapter will summarize the research study and highlight the limitations encountered. Recommendations will be made based on the conclusions drawn from the findings.

## 5.1 SUMMARY

The survey was conducted on 197 men aged 18 years and above. Selection of respondents into the sample was through the systematic sampling method (with a random start). Data was collected using a structured interview schedule. The researcher was the sole data collector.

## 5.2 SUMMARY OF THE FINDINGS

A summary of the findings will be presented below.

## 5.3 DEMOGRAPHIC DATA

The study revealed the majority, 100 (50.8%) of the respondents to be young and below the age of 30 years. In addition, the majority of the respondents, 167 (84.8%), at least had a primary level of education. Only 30 (15.2%) respondents did not have any form

of education at all. The single and cohabiting groups combined together were in the majority (66.5%) compared to those who were currently married or had been previously married (33.5%). The employment rate was high although based on the low educational levels it can be assumed that occupations were not in the high income brackets. It was only a minority (2.5%) of respondents who did not have a specific religion. The Kalanga ethnic group was represented by the majority of the respondents.

## 5.4 KNOWLEDGE POSSESSED BY MEN ON HIV/AIDS

The majority of the respondents had some knowledge of HIV/AIDS and could at least describe its transmission, signs and symptoms and prevention. However, two (1.0%) respondents possessed knowledge that was not based on scientific information.

## 5.5 MEDICAL EFFECTS OF HIV/AIDS ON CHILDBEARING AS VIEWED BY MEN

Respondents could perceive some effects of HIV/AIDS on childbearing. Several effects were mentioned, for example vertical transmission of HIV to the fetus was the commonest followed by maternal ill health as the second most perceived. However, a very small minority (1%) could not perceive any effects as they stated not to have any knowledge of such effects or felt the condition had no effect on childbearing.

Awareness existed among respondents that childbearing could have negative effects on the progress of HIV/AIDS. A smaller group (40.6%) of respondents did not know what effects childbearing may have on the progress of HIV/AIDS.

It can be concluded that most respondents were aware of the real danger posed by HIV/AIDS in childbearing and the effect that childbearing may have on the condition. It is important though to note that some men still lack this awareness.

## 5.6 EMOTIONAL EFFECTS OF HIV/AIDS ON CHILDBEARING AS VIEWED BY MEN

Most respondents mentioned a variety of emotional concerns regarding HIV/AIDS in childbearing that bother women, men and others. Death was the commonest cause for concern associated with all these groups of people.

The findings of this study suggest that the respondents view the ultimate result of HIV/AIDS to be death and that it is responsible for many emotional problems in society. Furthermore they did not view a positive HIV status and AIDS to be responsible for emotional problems in society.

## 5.7 SOCIAL EFFECTS OF HIV/AIDS ON CHILDBEARING AS VIEWED BY MEN

Findings illustrate that loss of lives was still viewed as the biggest social effect of HIV/AIDS. Other social effects that were mentioned related to economic problems. Despite widespread awareness within the group 20.3% of the respondents could not perceive any social problems resulting from HIV/AIDS. Thus despite men's perceptions of the wider effects of HIV/AIDS on society, understanding is limited.

## 5.8 MEN'S PERCEPTIONS REGARDING RESPONSIBILITIES CONCERNING DECISION-MAKING AND CHILDBEARING IN RELATION TO HIV/AIDS

The findings reveal that the majority (57.9%) of the respondents believe that men control childbearing decisions. The explanation to the belief was that, the control men have in this area is part of their control in many other family matters in their role as family head. The finding is in line with traditional Tswana culture applying to most ethnic groups in the country. On the other hand a smaller group (27.9%) of respondents indicated that childbearing decisions are controlled by both men and women. The basis for this response was that childbearing is a joint venture. An even smaller group (13.7%) stated that women control these decisions because they are the child bearers. These findings suggest that although men still widely view childbearing decisions in the traditional context, some are gradually beginning to change their views. The impression is that these change proponents wish to see women being given a fair share in the decision-making.

Contradictory to the findings that men are seen as the major controllers of childbearing decisions, the majority of the respondents did not believe that culture influences childbearing decisions. The comments, suggestions and questions reveal that men have a lot of information to offer in the struggle against HIV/AIDS. But they also have many unanswered questions regarding the subject.

## 5.9 ASSOCIATION EMERGING BETWEEN DEMOGRAPHIC INFORMATION AND RESPONSES

The study revealed some association between perceived emotional effects of HIV/AIDS on women and age of respondents, as well as on religion and control of childbearing decisions. The association may be an indication that different patterns of thought exist within various subgroups of the population. To understand these patterns more research is required in the various population groups, such as men. Specific health education programmes could be derived from such knowledge.

## 5.10 LIMITATIONS

The limitations will be discussed under the following headings: sampling and practical problems.

### 5.10.1 SAMPLING

Reservations on generalisation of findings are held for the following reasons:

- a relatively small sample (197 respondents) was interviewed, therefore findings may not accurately represent perceptions of the whole group of men in the settlement or in the nation as a whole.
- interviews were conducted on men in the informal settlement and findings may not be representative of other men's perceptions in different settings.

### 5.10.2 PRACTICAL PROBLEMS

- The researcher was concerned about her safety, therefore she had to conduct interviews at times deemed safe.
- Women were eager to participate in the interviews and the researcher had to explain in detail why they could not be interviewed.
- The researcher spent time locating households selected into the sample. At times no qualifying males were found in the households and the researcher had to move on. This was time consuming.

## 5.11 RECOMMENDATIONS

Recommendations will be made under the following headings:

- Nursing practice
- Nursing education
- Nursing research

### 5.11.1 NURSING PRACTICE

- In educating men on HIV/AIDS, nurses must consider the identified areas in which men lack information. One such area is a deficiency in basic facts about the condition. In addition the education must place emphasis on engendering a deeper understanding about HIV/AIDS to enable appreciation of its wider

effects, for example a loss of labour force and an increase in care costs resulting in economic collapse.

- Education of women on HIV/AIDS on childbearing must be done in view of factors likely to inhibit change. The role of men in childbearing decisions as suggested by the study must be considered in attempting to empower women for change.
- Education of the public must be mainly focused on effecting sexual behavioural change which is still a major obstacle in HIV preventive attempts.
- Health education to the public must be done in view of the social class of the people addressed, for example informal settlement dwellers. This is in view of the fact that one's life experiences may influence perceptions of health and disease.
- Nurses must appreciate the cultural diversity of their patients, in order to identify the various perspectives on HIV/AIDS in childbearing, hence be able to offer culture specific education to patients on the condition. This will facilitate taking advantage of cultural beliefs to effect desired change.

### 5.11.2 NURSING EDUCATION

- The nursing curriculum needs must include content reflecting the complexities of AIDS. Students must be made to appreciate the importance of a multidimensional approach in dealing with the problem. The importance of utilizing research information and generating more research information in dealing with the disease must be emphasized.

- The learning strategies used to deliver curricular content must ensure that students are equipped with good techniques of health education. This will overcome the difficulty associated with public education.
- The curriculum must ensure that students are well aware of the cultural diversity of the people they serve. This will enable them to become culture sensitive in providing care to HIV/AIDS patients and health education.

### 5.11.3 NURSING RESEARCH

- Similar studies must be conducted on men in other settings (communities) and social classes, in order to reveal their specific needs so that appropriate educational strategies for HIV prevention can be developed for various population subgroups.
- Further studies addressing men must be done to improve the data base on men's sexuality to complement existing information on women, to facilitate development of gender specific educational programmes.
- Correlational research is required on HIV/AIDS in childbearing to improve understanding of people's resistance towards efforts aimed at changing behaviour.
- A replication of this study must be done at a larger scale in order to generalize findings to the population under study and to compare findings.

## 5.12 CONCLUSION

The objectives of this study were to identify:

- the demographic characteristics of the respondent
- knowledge possessed by men on HIV/AIDS
- the medical effects of HIV/AIDS on childbearing as viewed by men
- the emotional effects of HIV/AIDS on childbearing as viewed by men
- the social effects of HIV/AIDS on childbearing as viewed by men
- men's perceptions regarding responsibilities concerning decision-making in childbearing in relation to HIV/AIDS
- any association emerging between demographic information and responses.

Findings showed that the study was able to describe all the variables under study, therefore meeting the set objectives. The findings imply that men in this settlement are likely to practice both positive and negative behaviours in view of HIV transmission. Educational strategies must be aimed at encouraging positive behaviours and discouraging the negative ones.

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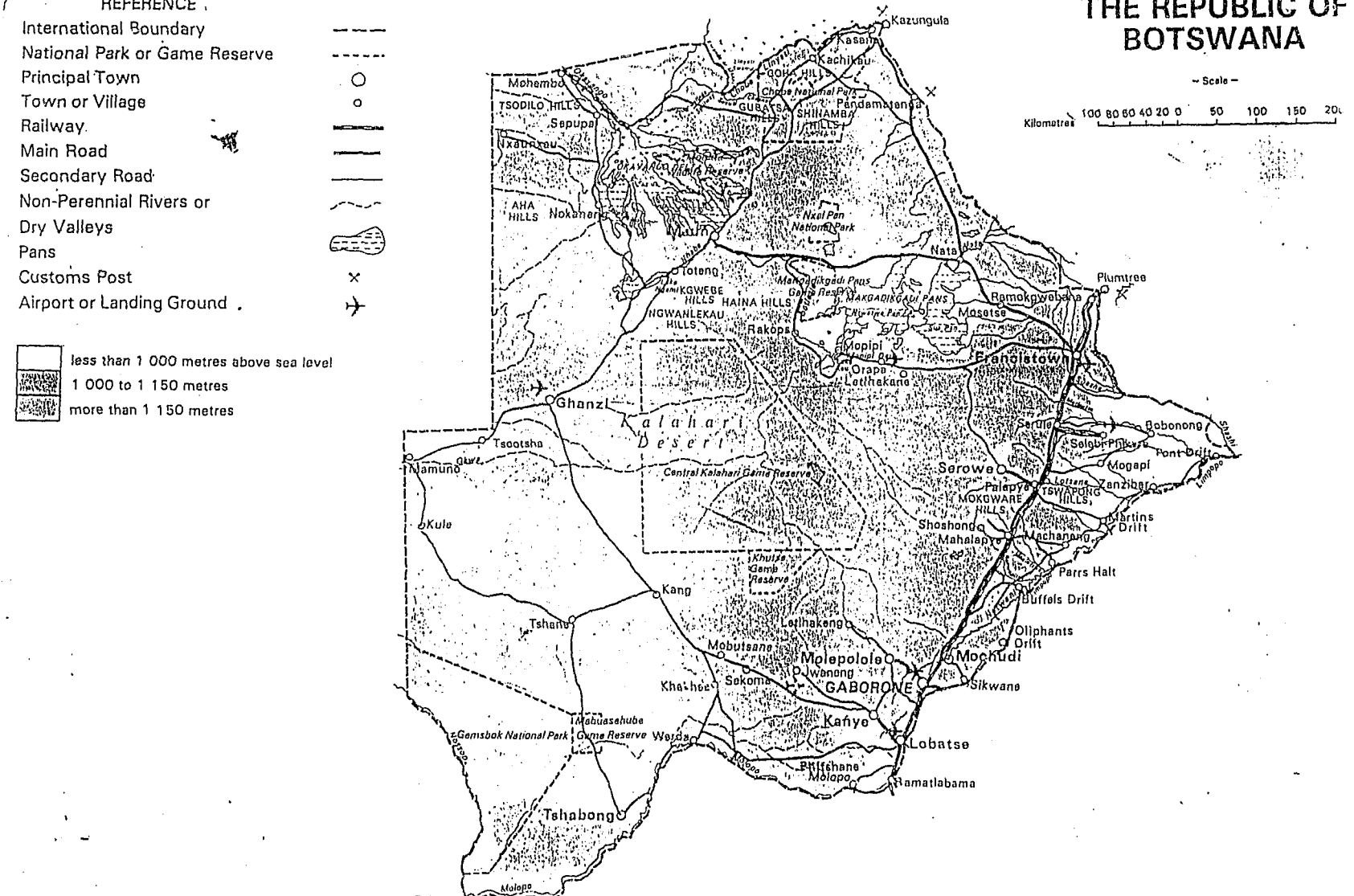
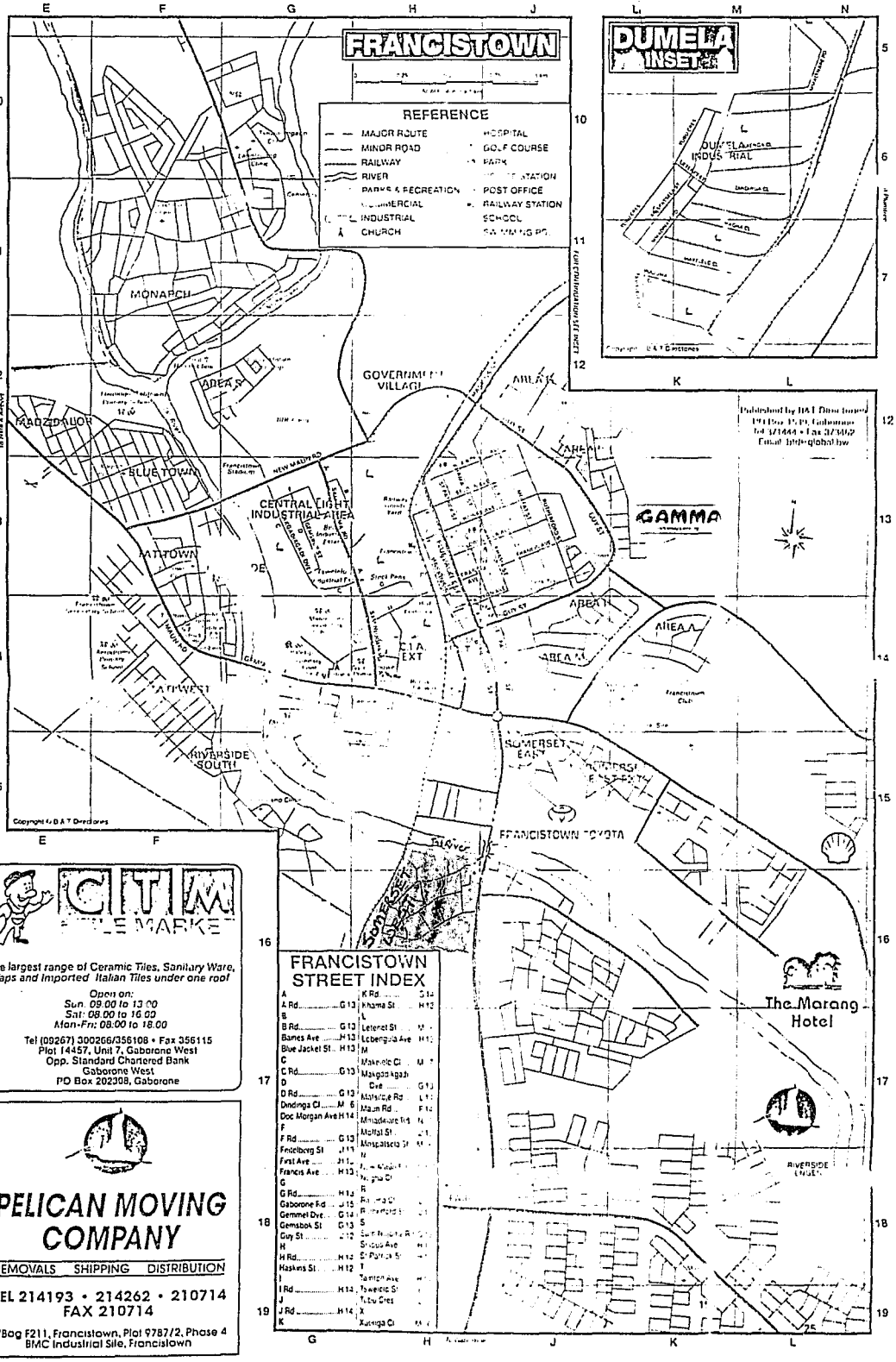
# APPENDIX ONE

# THE REPUBLIC OF BOTSWANA



# APPENDIX TWO

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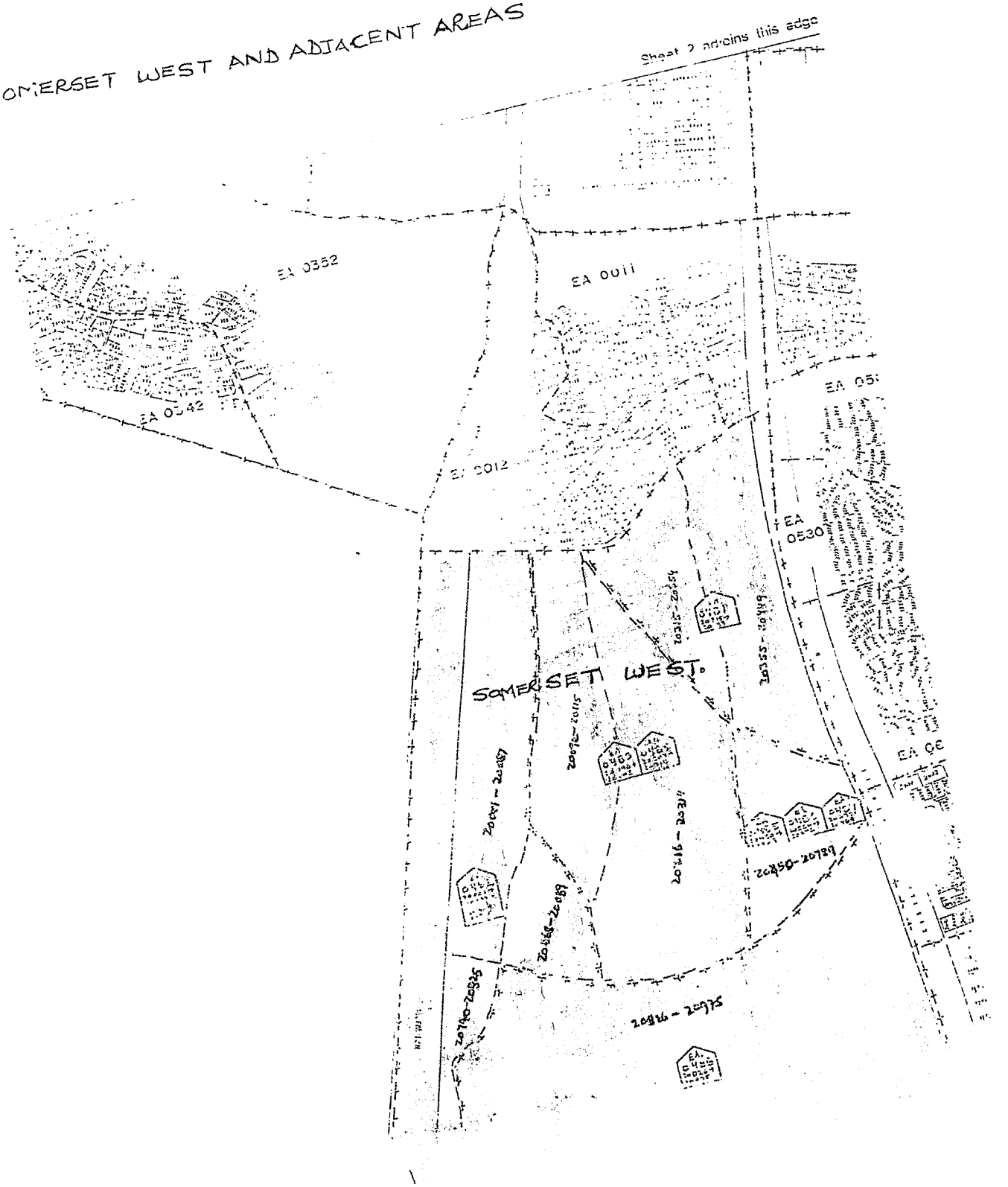
# APPENDIX THREE

SOMERSET WEST AND ADJACENT AREAS



# APPENDIX FOUR

## STRUCTURE INTERVIEW SCHEDULE

### DEMOGRAPHIC DATA

| | | |
|---|---|---|
| 1. AGE IN YEARS | 16 - 20 | |
| | 21 - 25 | |
| | 26 - 30 | |
| | 31 - 35 | |
| | 36 - 40 | |
| | 41 - 45 | |
| | 46 - 50 | |
| | 51 - 55 | |
| | 56 - 60 | |
| | 61 + | |

| | | |
|---|---|---|
| 2. EDUCATIONAL STATUS | PRIMARY | |
| | SECONDARY | |
| | TERTIARY | |

| | | |
|---|---|---|
| 3. MARITAL STATUS | MARRIED | |
| | SINGLE | |
| | DIVORCED | |
| | WIDOWED | |
| | COHABITING | |

| | | |
|---|---|---|
| 4. OCCUPATION | EMPLOYED | |
| | SELF-EMPLOYED | |
| | UNEMPLOYED | |

| | | |
|---|---|---|
| 5. RELIGION | CHRISTIAN | |
| | MUSLIM | |
| | HINDU | |
| | OTHER | |
| | NONE | |
| | TRADITIONAL BELIEF | |

6. ETHNICITY SPECIFY:

KNOWLEDGE

7. Have you heard about HIV/AIDS

| | |
|---|---|
| YES | |
| NO | |

If yes please explain.

---

PERCEPTIONS OF MEDICAL EFFECTS OF HIV/AIDS ON CHILDBEARING

8. How does HIV/AIDS affect childbearing?

9. How does childbearing affect HIV/AIDS?

PERCEPTIONS OF EMOTIONAL EFFECTS OF HIV/AIDS ON CHILDBEARING

10. Do you think women are emotionally/mentally affected by HIV/AIDS in childbearing?

| | |
|---|---|
| Yes | |
| No | |

If yes, explain.

11. Do you think men are emotionally/mentally affected by HIV/AIDS in childbearing?

| | |
|---|---|
| Yes | |
| No | |

If yes, explain.

12. Are there any others who you think are affected?

| | |
|---|---|
| Yes | |
| No | |

If yes, who and how?

13. What do you think are the emotional/mental effects of HIV/AIDS in childbearing on the community and society at large?

## PERCEPTIONS OF SOCIAL EFFECTS OF HIV/AIDS IN CHILDBEARING

14. Do you think HIV/AIDS in childbearing affects society?

| | |
|---|---|
| Yes | |
| No | |

If yes, explain.

15. How big do you think are social problems resulting from HIV/AIDS in childbearing?

## PERCEPTIONS OF MEN REGARDING RESPONSIBILITIES CONCERNING DECISION-MAKING AND CHILDBEARING IN RELATION TO HIV/AIDS

16. Who do you think has more control in childbearing decisions?

| | |
|---|---|
| Men | |
| Women | |
| Others | |

17. In your viewpoint, do you think this is right?

| | |
|---|---|
| Yes | |
| No | |

Explain your answer.

18. Are there any responsibilities regarding decision-making in childbearing?

| | |
|---|---|
| Yes | |
| No | |

If yes, explain.

19. Do you believe that there are cultural beliefs influencing decision-making?

| | |
|---|---|
| Yes | |
| No | |

If yes, explain.

20. Please say anything else that you think has not been included above which is linked to HIV/AIDS in childbearing.

# APPENDIX FIVE

INFORMATION SHEET

TO BE GIVEN TO EVERY RESPONDENT

My name is Tinaye Sonto Mmusi. I am a 2nd year student at the Witwatersrand University - South Africa, studying for a Master of Science Degree (Nursing). To complete the course I am required to carry out a research project. I am doing a study on the beliefs of men about how HIV/AIDS affects childbearing.

I promise that your name will not be associated with the information you give. This will be done by not writing your name on the sheet of questions; so you will remain anonymous. I further promise that you will not be harmed in any way nor will your care at any health facility be affected by participating in this study or the way you answer questions. So please feel free to give me your real thoughts. Together, we will find a private place to talk. This talk will not last more than 30 minutes unless it is your wish.

Remember that you are not forced to participate and are free to withdraw from the project at any time. Tank you for reading this letter and listening. May I please know if you will participate?

# APPENDIX SIX

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)
Ref: R14/49 Mmusi

CLEARANCE CERTIFICATE PROTOCOL NUMBER M980531

| | |
|---|---|
| PROJECT | Men's Perceptions Of The Effects Of Human Immunodeficiency Virus/Acquired Immuno-Deficiency Syndrome On Childbearing In An Informal Settlement In Francistown (Botswana) |
| INVESTIGATORS | Mrs TS Mmusi |
| DEPARTMENT | Dept of Nursing Education, Wits University |
| DATE CONSIDERED | 980529 |

DECISION OF THE COMMITTEE *

Approved unconditionally

DATE 980612 CHAIRMAN.....(Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Miss P McInerney
Dept of Dept of Nursing Education, Wits University

Works2\lain0015\HumEth97.wdb\M 980531

# APPENDIX SEVEN

TELEGRAMS: PULA

TELEPHONE: 350800
TELEX 2655 BD

REPUBLIC OF BOTSWANA

OFFICE OF THE PRESIDENT

PRIVATE BAG 001

GABORONE

OP 46/1 LXX (22)

31 August 1998

Ms Tinaye S. Mmusi
University of Witwatersrand
Faculty of Health Sciences
Nursing Department
Parktown 2193
Johannesburg
Republic of South Africa

Dear Madam,

RE: GRANT OF A RESEARCH PERMIT: T. MMUSI

Your application dated July 8, 1998 refers.

We are pleased to inform you that you have been granted permission to conduct research on "Men's Perceptions of the Effects of Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome (HIV/AIDS) on Child Bearing in an Informal Settlement in Francistown.

The permit is valid for a period not exceeding eight (8) months, effective 31st August 1998.

The permit is granted subject to the following conditions:

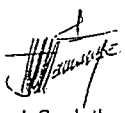
1. Copies of any papers written as a result of the study are directly deposited with the Office of the President, National Archives, (2 copies each), National Library Services, National Institute for Research , University of Botswana Library and the Ministry of Health.

2. The team comprises only Ms Tinaye Mmusi.

3. The study is conducted according to the particulars furnished in the application.

4. You work in close liaison with the Ministry of Health
5. This permit does not give authority to enter any premises, private establishment or protected area. Permission for such entry should be negotiated with those concerned.

Yours faithfully



J.Sethibe
for/PERMANENT SECRETARY TO THE PRESIDENT

cc: Permanent Secretary
Ministry of Health
Director, National Institute for Research
Director, National Library Services
Government Archivist
Librarian, University of Botswana Library
District Commissioner, Francistown
City Clerk Francistown

**Author** Mmusi T S
**Name of thesis** A Study On Men'S Perceptions Of The Effects Of Hiv/Aids On Childbearing In An Informal Settlement In Francistown (Botswana) Mmusi T S 1999

***PUBLISHER:***
**University of the Witwatersrand, Johannesburg**
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