Botswana's Public Health Crisis: The HIV/AIDS Epidemic
A Case Study of Botswana and Uganda

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University of Colorado at Boulder

By Gabrielle Onessimo

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The HIV/AIDS Epidemic: Botswana's Public Health Crisis

Abstract

In this paper, I aim to answer the question: why are HIV rates in Botswana so high? The HIV epidemic in Botswana is a public health crisis that has dramatically affected the people of Botswana. Through comparative analysis with Uganda, a sub-Saharan African success story in terms of HIV, I argue that cultural and economic factors are responsible for high HIV rates in Botswana.

Cultural norms such as oppressive gender norms, a lack of knowledge surrounding the HIV virus, and a lack of sex education contribute to why Botswana has been unable to confront this serious epidemic. Uganda has been far more successful in engaging women in politics and the work force than Botswana. I argue that the oppression of women in Botswana has exacerbated the health epidemic.

Sex education and information surrounding safe sex practices are far better distributed and understood in Uganda than in Botswana. Mandatory sex education programs for the Ugandan youth have been very useful in promoting awareness and comprehension. The taboo nature of sex in Botswana creates a norm of secrecy, resulting in a young population that is uninformed about safe sex practices and disease contraction.

The issue of unequal gender norms becomes prominent again as I argue that economic inequality between genders within the nation is responsible for phenomena such as transactional sex, increasing the spread of HIV. Because women are far less engaged in the professional sector than their male counterparts, many women feel reliant on the financial support of men. In Uganda, because women play an active role in the professional and political realms, they are able to feel empowered and avoid reliance upon a man for financial stability. Female politicians also have a vested interest in providing services that are beneficial for the health of other women. Women may remain an at risk group for HIV in Botswana until unequal gender norms in the nation are confronted.

I conclude my argument by dismissing three common arguments used to explain high HIV rates; laws and stigma against homosexuality, general poverty, and biology. While these arguments are commonly presented as explanations for high HIV rates in sub-Saharan Africa, they each invoke glaring flaws. Biased and inaccurate data surrounding homosexuality in the region renders any explanation of this sort unsound. I argue that anti-homosexuality norms are very prominent throughout nearly the entirety of the region, and cannot be directly correlated to HIV rates. Data would seem to indicate that wealthier people are actually more at risk of HIV within a nation and that wealthier nations may have higher HIV rates, disproving the previously assumed stance that poverty and high HIV rates must be positively correlated. While certain different subtypes of HIV might have different levels of pathogenicity, I argue this has no effect on the HIV epidemic in sub-Saharan Africa.

Introduction

Botswana has the second highest rate of HIV infection of any nation in the world (24.8%) other than Swaziland (26%) (UNICEF, 2015). In 2014, it is estimated that about 5,100/2.2 million people in Botswana died of HIV, and this statistic does not include individuals who died of medical issues that arose as repercussions of the virus, such as tuberculosis, high fever, etc. (UNAIDS, 2014). It is also estimated that 67,000 children between the ages of 0-17 have been orphaned due to HIV/AIDS in Botswana.

Why does Botswana have such a high rate of HIV/AIDS? Botswana's high HIV rate is particularly puzzling because of its high GDP per capita of $7,315 as of 2013 (World Bank, 2013). Moreover, other SSA countries have found success, many with much lower GDP/capita. For example, The Democratic Republic of the Congo has one of the lowest GDPs per capita in the world; approximately $484USD as of 2013 (World Bank, 2013), with an HIV rate of about 1% (UNAIDS, 2014). In fact, several of sub-Saharan Africa's highest ranking countries in terms of GDP are found in Southern Africa while "Southern Africa alone accounted for almost one third (32%) of all new HIV infections and AIDS deaths globally in 2007" (UNAIDS Epidemic Update, 2007). Research has been completed by several nongovernmental organizations and scholars exploring the various facets of Botswana society in search of causal links to the HIV/AIDS epidemic. Though there are several theories, those studying public health in Botswana have yet to provide a definitive and convincing answer.

In this paper, I will explore Botswana's high HIV/AIDS rates by conducting a comparative analysis between Botswana and Uganda. I consider why Botswana has been unable to address this major public health disaster through cultural and economic comparison with Uganda.

I argue that two overarching factors are responsible for the HIV/AIDS epidemic in Botswana: cultural forces and economic disparities. Though there are many other potential factors, for the purpose of this thesis and the case study between these two nations specifically, cultural implications and economic inequality are the most relevant and prominent contributors to high HIV rates in Botswana. Variables such as government initiatives and their lack of success also play a huge role in the public health crisis, however the lack of success can be attributed to cultural practices and ideologies, and will therefore be discussed in the cultural section of this analysis. I will then dismiss three very common arguments used to explain high HIV rates in sub-Saharan Africa; the biology of the disease, general poverty, and stigma against homosexuality.

I proceed as follows; I will analyze the cultural factors that have impacted the HIV epidemic in Botswana and in Uganda. Cultural practices that influence HIV include oppressive gender norms, and a lack of education surrounding safe sex (particularly for women). I will compare the understanding of HIV in Botswana to that in Uganda, and the role that women play to that in Ugandan society. Various cultural stigma in Botswana also contribute to the epidemic; such as the stigma against HIV infected persons, and the implications of this stigma. I will finish the cultural section of this analysis by demonstrating the lack of success of government HIV initiatives because of cultural responses and ideologies in Botswana. I will contrast these findings with the Ugandan response to various government initiatives. Through these comparisons, I hope to identify what cultural differences exist between the two nations that may be observed and the effect these differences play on the HIV epidemic.

The following section of this paper will address the economic barriers to the eradication of the HIV virus in Botswana. In this section, I elaborate on the extensive potential health risks Botswana citizens face due to the large wealth gap in the nation. By explaining how an

individual's risk of disease contraction is ultimately very affected by their socioeconomic status, I will demonstrate how certain individuals in Botswana are more at risk than those in Uganda.

The issue of unequal gender roles arises again from an economic perspective in the following portion of my analysis. Women face a serious risk of STD contraction by engaging in intergenerational relationships or transactional sex. Through comparison of female labor force participation in Botswana and in Uganda, as well as other gender equality indicators, I argue that women's subordinate economic status to men places them and their sexual partners at high risk of HIV transmission and contraction.

Lastly, I will then devote a portion of my analysis to disproving factors that are very commonly presumed to be positively correlated with HIV. In many cases, oversimplification and assumption have led researchers to believe that certain cultural beliefs and economic issues contribute to HIV in ways that may not necessarily be true. Specifically, I argue that the stigma against homosexuality, general poverty, and biology do not play a role in Botswana's HIV epidemic. By dismissing commonly accepted schools of thought that are not necessarily accurate, I will further demonstrate that perhaps less commonly accepted theories are deserving of more consideration.

Comparative Statistics[1]

	Botswana	**Uganda**	**SSA**
GDP (2013)	14.87 billion USD	21.49 billion USD	1.7 trillion USD
GDP (pc) (2013)	7,314 USD	571.96 USD	3,543.6 USD
Population (2013)	2.02 million	37.58 million	800 million
HIV rate 1990s	24.3%	30%	no data

[1] These statistics all came from UNAIDS 2012/ 2013, and the World Bank, 2013

HIV rate 2000s	29%	24.3%	-18%
HIV rate 2006	27.1%	6.4%	18.8%
HIV rate 2013	24.8%	7.4%	9%
Fertility rate 2013	2.62	5.89	5.05
Female LFP	75.1%	77%	64%
Male LFP	83%	80%	77.3%
LFP gender gap	~8%	~3%	64%
Life expectancy 2012	46.99%	58.65%	58%
GINI coefficient	0.5	0.42	0.45
HIV rate among females (2012)	20.4%		58% of HIV victims are female
HIV rate among males (2012)	17.6%		

Background on HIV/AIDS in Botswana and Uganda

Human immunodeficiency virus (HIV) is believed to have mutated from a disease called SIV, or simian immunodeficiency virus, which is found in apes. Many hypothesize that SIV was able to mutate to HIV by humans hunting infected apes and either eating them or coming in contact with the infected blood. The first known case of HIV-1 was discovered in a blood sample from 1959 in Kinshasa, Democratic Republic of the Congo (The AIDS Institute, 2010), though it is quite possible that the first case of HIV could have occurred before 1959. It was not until 1983 that scientists discovered that the illness AIDS was caused by the virus HIV (The AIDS Institute, 2010).

The first case of HIV in Botswana was reported in 1985 (Botswana: Summary Country Profile For HIV/AIDS Treatment Scale-Up, 2005). Initially, the disease was not taken very seriously; and the Botswana media downplayed the dangers of the illness (Keene, 2001). The media depicted HIV as an illness that came only from foreigners and from homosexuals. In fact,

after the first few cases of HIV were diagnosed in Botswana, an official government statement was released stating “It’s not a problem in Botswana. AIDS is primarily a disease of homosexuals and there are no homosexuals in Botswana” (MacDonald, 1996, p.1328). As the country failed to acknowledge the severity and deny the dangers of the virus, the HIV infection rate rose quickly and soon became a major epidemic (SARPN, 2008). The first national HIV program was not introduced until 1988 (AVERT, 2013). However, many of these programs became essentially irrelevant by the 1990s (Allen, Heald, 2004).

The HIV rate in the nation steadily increased throughout the 1990s. In 1991, the infection rate was about 9.1 percent, and by 1995 the infection rate reached about 21.8% (World Bank, 2013). The 1990s were a critical time in the HIV epidemic, as countries were presented with the opportunity to confront the virus early. However, in the case of Botswana, the virus continued to spread as little effort was devoted to what became a major public health crisis.

Though in recent years Botswana has seen a slight decline in HIV infections, the results have been far less impressive than what the rest of the international community had expected. In 2011, Botswana saw HIV rates of about 25.8%, and by 2014 the HIV infection rate was closer to 25.2% (World Bank, 2013). Deaths from HIV have decreased significantly over time in Botswana as antiretroviral drugs became more accessible and knowledge about ARVs increased. In 2005, approximately 14,000 Botswana citizens died of HIV out of a population of 1.876 million people. In 2013, this number was reduced to approximately 5,800 deaths out of a population of 2.02 million people. (AVERT, 2013). While the country can take some relief in the fact that there has been a significant decline in HIV related deaths, this is not to be confused with the overall infection rate. While ARVs are successful in treating HIV/AIDS, there is no cure for HIV.

The first case of HIV in Uganda was detected in 1982. During the early to mid-1980s, it was estimated that about 30% of the population was HIV infected. Presently, the HIV prevalence rate is about 7.4%, and was even lower until very recently. Between the 1990s and now; through immediate action, effective media campaigns, and much more; rates have almost consistently fallen yearly, and public lath progress is continually made. Uganda has been considered a major success story in combating HIV. in 2004, UNAIDS stated that Uganda was "one of the world's earliest and most compelling national success stories in combating the spread of HIV" (Green et al, 2006). Uganda is studied as a very fascinating success story because of its classification as a low income country, as well as its violent and oppressive political history.

Methods

By comparing these two countries, I seek explanations as to why Botswana's current public health situation has fared so much more poorly than Uganda's. Uganda provides a useful comparison to Botswana for several reasons. First, Botswana gained independence just four years after Uganda, and both countries were former British colonies. Second, both Uganda and Botswana were faced with the early threat of HIV at similar times, in the mid 1980s. Third, both countries also share some similar cultural views, such as conservative views on homosexuality and similar historical backgrounds. The religious makeup of each country is also quite similar, both sharing a strong Christian majority. Uganda provides an interesting comparison to Botswana because Botswana is a much wealthier nation, which makes Uganda's relative public health success complicated and even contradictory from a theoretical standpoint. Both Uganda and Botswana are considerably remarkable for opposing reasons; Uganda for its extraordinary success and Botswana for its gross failure.

Because Botswana and Uganda do share many cultural and historical similarities, we are able to control for certain variables. My comparison consists of five varying schools of thought that could account for a country's level of success in defeating HIV/AIDS. I will focus on two factors that explain the differences in HIV rates between the two countries. I will then dismiss three factors that are commonly used to explain differences in HIV rates across nations.

First, I argue that culturally and legally oppressive gender roles in Botswana contribute to HIV rates within the nation. I also make the argument that stigma against HIV infected persons and a lack of understanding around HIV and safe sex in Botswana contribute to high HIV rates. I will then contrast the gender roles and stigma in Botswana to those in Uganda. I will conclude this section of my analysis by evaluating the cultural reactions to government initiatives to reduce HIV transmission rates in both nations. These cultural reactions are able to serve as reasoning for why seemingly useful and beneficial programs have had little success in Botswana, while they have been wildly successful in Uganda.

Second, I will then argue that income inequality between men and women plays a huge role in HIV rates within a nation. In this section of the analysis, I will elaborate on the between group income inequality between men and women that is present in Botswana, and how that has aggravated the epidemic. Firstly, income inequality between genders in the nation has created a culture of intergenerational and transactional sex. Income inequality in the nation also leads women to engage in sex work as a sole means of income generation. I compare the between-group income inequality between men and women in Botswana to that in Uganda in order to establish a link between female professional empowerment and public health.

I then dismiss three commonly made arguments. The first is that the biology of the disease plays a role in the spread of HIV in sub-Saharan Africa, particularly in Southern Africa.

The biology of HIV, meaning the strain of the virus, is often cited as a seemingly obvious explanation for high HIV rates in specific nations and geographic locations. HIV is divided by medical professionals into two strains, both of which are then broken down further into many subtypes. Though different strains do perhaps have different ramifications, I will demonstrate that this argument in invalid in the case of Botswana.

The second argument I dismiss is that general poverty is positively correlated with HIV. Many have deduced that poor nations are more likely to have high HIV rates. This seems like a simple conclusion to draw, however this is a gross oversimplification. By analyzing countries with very low GDPs and comparing those with countries with high HIV rates, we see that these countries are often not the same. This would seem to indicate that general poverty cannot be sited as them main or even an obvious contributor to HIV rates. While poverty may limit access to HIV treatment drugs or medical care, poorer countries tend to have lower HIV rates than their wealthier counterparts. While other variables must be considered as we evaluate this correlation, this does seem to raise issue with the commonly assumed notion that nations with low GDPs are more likely to have high HIV rates.

The third argument I will dismiss is that homosexuality and stigma against homosexuality plays a role in HIV rates in SSA. While there is a plethora of research published concerning the link between stigma and laws against homosexuality leading to high HIV rates, this argument is invalid in the context of SSA. Uganda, which is mostly frequently cited as sub-Saharan Africa's most major success story in terms of battling HIV, has one of the most extreme stigma against homosexuality in the world. Because stigma against homosexuality is very common throughout the entirety of Africa, I argue that one cannot conclude any sort of relationship between HIV rates and this stigma, specifically in the context of sub-Saharan Africa.

Argument: Cultural Ideologies

In this section, I will argue that Botswana culture plays a big role in high HIV rates in the region. This section is comprised of several separate subsections. The cultural phenomena I argue are linked to high HIV rates are oppressive gender roles, a lack of understanding of the HIV virus, and the culture of sex education. I argue that women are more at risk of HIV contraction in Botswana because of their lack of participation in the work force and in politics. I also argue that the oppressive dynamic of personal relationships between men and women in the nation increases a woman's risk of HIV. Because women are subordinate in both professional and personal realms in Botswana, I argue that they are a very at-risk group. In the last portion of this section of the argument, I contend that because Ugandan women are far more actively involved in the workforce and in politics than Botswana woman, women are a less at-risk group for HIV. I argue that the political empowerment of women in Uganda has been extremely beneficial for women's health, and in passing legislature that has been essential in protecting the rights of women.

I then argue that culturally, HIV is very misunderstood in Botswana which leads to higher risk of contraction. I argue that people are unable to protect themselves from the risk of HIV if they are unsure of how contraction occurs. I contrast the lack of information regarding HIV in Botswana with the more accurate understanding of HIV that we observe in Uganda. I explore the various reasons why Ugandans generally have a better comprehension of HIV than Botswana citizens and how this understanding of the virus allows for lower HIV rates.

In the final section of my cultural argument, I argue that a lack of sex education in Botswana correlates to high HIV rates, especially in women and the youth demographics. I contrast the lack of safe sex education in Botswana to the mandatory sex education programs in

Uganda to display the link between safe sex education and safe sex practices. I argue that the cultural unspeakable nature of sex in Botswana creates a generation of young people who lack the knowledge and tools to protect themselves and their sexual health.

Oppressive Gender Roles and Relations

Women face a much higher risk of HIV contraction than men. This is partially due to the fact that women are biologically more susceptible to HIV infection. This is because "the vagina has a larger area (compared to the penis), that can be exposed to HIV-infected semen" (Office on Women's Health, 2011). However, one would be oversimplifying in the assumption that the reason women are a more at-risk group for HIV than men is solely biological. While it is common to see that women are disproportionately affected by HIV in sub-Saharan Africa, this is not a trend that we observe globally. In the United States for instance, women only accounted for 20% of new HIV infections in 2010 (CDC, 2015). As of 2011, only 23% of HIV infected people in the United States were women (CDC, 2015). However, in Botswana, more than 50% of HIV infected individuals are women (AVERT, 2013), while women make up almost exactly 50% of the population (50.04%) (Trading Economics, 2014). Therefore, one must question: what would explain why women are so much more at risk of HIV contraction specifically in SSA? I argue that the reason women face a higher risk for STD and HIV contraction is because of oppressive and unequal gender norms in the region that place women and their sexual health at risk.

The strong effect that HIV has on women is often ignored, as many view HIV primarily as a disease that mainly affects men who have sex with men. However, women are in fact far more vulnerable to HIV than men throughout the majority of Africa because of their subordinate status in both the professional and social fields.

While patriarchal values are present nearly everywhere in the world, they are especially prominent in developing countries. In developing countries, women face dramatic socio-economic gaps that their male counterparts may not face. In sub-Saharan Africa, women face obstacles such as a lack of quality education and societal pressures and expectations (Keene, 2001). In 2013, UNAIDS estimated that HIV prevalence among women was about 20.8%, whereas HIV prevalence among men was closer to 15.6% in Botswana (UNAIDS, 2014). In some areas of Botswana, "HIV-rates in girls between the ages of 15 and 19 are nine times more than that of boys of the same age" (Leclerc-Madlala, 2008).

We observe a major educational gap between men and women in sub-Saharan Africa, which puts women disproportionately at risk of HIV. Factors such as "measures of literacy, enrollment, and years in school- reveal important patterns and trends in women's education in developing countries. Each of these indicators leads to the same conclusions: the level of education is low in the poorest countries, with just a handful of exceptions, and by any measure, the gender gap is largest in these countries" (King, Hill, 1997). Where female education levels are low, HIV risk increases significantly. A study conducted of 32 developing nations "found that women who had some level of secondary education were five times more likely than non-literate women to have knowledge of HIV" (AVERT: Women and HIV/AIDS, 2015). The education gap puts women more at risk due to a lack of public health knowledge. Without an understanding of the disease, women may be unable to protect themselves from it.

Women also face many societal expectations that put them more at risk of HIV contraction. For example, women are expected to take on a more passive sexual role. Women are also expected to maintain their innocence until marriage, implying that "[t]raditional norms of virginity for unmarried girls impede young women's freedom to seek important sexual health

information, including knowledge about HIV risk" (Interagency Coalition on AIDS and Development, 2006). Whether or not an unmarried woman is sexually active, she may avoid asking questions about her sexual health out of fear of judgement. Therefore, because of an insufficient sexual education, women are far less likely than men to understand safe sex, and may lack knowledge about how to protect themselves from HIV. Many, such as the UN, USAID, the Official Journal of the AIDS society, etc., have argued that the key to lowering HIV rates worldwide is to provide more equal opportunity for women.

Through a very active civil society and a fairly gender-progressive government, Ugandan groups have been able to provide more venues for women to obtain the information and medical help they need and to empower women to seek professional growth opportunities. Uganda was under the power of two very oppressive regimes from the early 70's until the 90's. Idi Amin, president from 1971 to 1979, and Milton Obote, who had been in power before Amin and then once again after him "[both] left everyone vulnerable to disease; however, women became one of the most susceptible populations in terms of HIV due to the legacy of these regimes" (Keene, p. 24). While Amin's regime was oppressive towards all Ugandans, women were particularly affected.

During this time, Uganda's sex worker population grew practically exponentially. This growing market introduced a very serious threat of HIV to female sex workers. While risky sex and prostitution can put everyone at risk, "women were more susceptible because they did not have much decision-making power. Men could choose whether or not to have safer sex, whether or not to rape, whether or not to sleep with a prostitute, but often women were in no position to make decisions regarding their sexuality and welfare" (Keene, p. 39). The HIV rates among sex workers became extraordinarily high. Many women who felt like they had no

opportunities for upward mobility other than to utilize their sexuality were placed in a no-win situation with very serious ramifications.

In the mid-80's, once Amin was no longer in power, a massive women's movement flourished in Uganda. Yoweri Museveni became president of Uganda in 1986; and unlike his predecessors, he supported the growth of women's groups in hopes that these groups would unite the nation and "rebuild the state" (Keene, 2001, p. 47). This started a huge women's liberation movement within the nation, which has become exemplary throughout the entire continent (Tripp, Kwesiga, 2002). In 1991, the Ministry of Women and Development became a full ministry, undertaking projects such as AIDS education and treatment for women and ensuring food security for women. Presently, Uganda has far above average female participation in parliament as compared to the average in sub-Saharan Africa. Female participation in parliament encourages discussion on discrimination against women and on women's issues.

Women in power in Uganda have been able to pass legislation that has been essential in protecting women from HIV and women's health generally. It is believed that "Uganda's women parliamentarians were instrumental in passing amendments to the penal code that made rape a capital offense and punished hotel owners for allowing prostitution on their premises" (Tripp, Kwsiga, p.79). The Ministry of Women and Development also played a major role in the decision to allow women to attend university, therefore allowing them to not only feel empowered and work towards an education, but allow them the chance to potentially be financially independent by providing access to higher education. By allowing women the opportunity to participate in politics and in civil society, a previously very high risk population is able to feel empowered and create laws and organizations to protect themselves.

For example, the Uganda Women Parliamentary Association (UWOPA) was established during the women's movement in 1989. Since its formation, the organization has made huge strides towards protecting and ensuring the rights of women and lowering HIV rates in the state. UWOPA has worked with different civil society groups to assist in the creation of "engendered laws", such as "the Domestic Violence Act, Prevention of Trafficking in Persons Act, Prohibition of Female and Genital mutilation Act" (UWOPA Strategic Plan, 2016). Female genital mutilation, also referred to as FGM or female circumcision dramatically increases a woman's risk of HIV contraction. This is because FGM leaves scar tissue, and during intercourse "disruption to the genital epithelium and exposure to blood during coitus appear to enhance the risk of infection" (Kun, 1997, p. 153). This law not only criminalizes FGM, but also promotes awareness that there is a positive correlation between FGM and HIV risk.

Women also play a more active role in the work force in general in Uganda than they do in Botswana. The gap between the percentage of female and male participation in the labor force is less than 4 percentage points (UN Women, 2015). The gender gap in labor force participation gap in Botswana is about 10% (World Bank, 2014). Moreover, in Botswana, female government participation has been observed far less frequently than in Uganda, despite the fact that Botswana has a larger and more productive economy than Uganda. In Uganda, 34.97% of national parliament seats are held by women, whereas in Botswana, only 9.52% of parliamentary seats are occupied by women (Find the Data, 2015). This would indicate that men hold a far more significant role in the professional and labor markets than their female counterparts.

Additionally, there has never been any notable women's movement in Botswana. With no powerful movement towards equality, women had "very little participation in politics and political parties" (Geisler, 1995). By the time the Botswana Council of Women did ultimately

form, it was mainly comprised of "the wives of ministers, parliamentarians and tribal leaders who engaged in activities related to social welfare and teaching African women the art of being a good housewife" (Geisler 1995, p. 550). The executive secretary of the group at the time stated, "when it came to discussing issues that were pertinent, we got a hostile reception, most of all from women" (Gesiler 1995, p. 550). Botswana's shallow attempt at a women's liberation movement was not nearly as effective in providing women with a place in the political or non-governmental realms as the women's movement in Uganda.

Many traditional values have also had strong influence over modern laws, often resulting in laws that are discriminatory towards women in Botswana. In colonial times, "general laws" were created by the British and applied only to the white settler population. Persons of African descent followed "traditional laws" that stemmed from oral traditions and values (Van Hook, 1994). Since independence, the "general laws" now apply to all inhabitants of Botswana. However, it has been observed that current "general laws" are "incorporating discriminatory elements of customary law into the statutory [general] legal system" (Human Rights Watch, 1994). While Ugandan female parliamentarians are working towards the modernization of discriminatory laws, traditional and old-fashioned laws still remain on the books in Botswana.

Marriage inequality

In Botswana, women have very few rights once they are married, making them very subordinate to their husbands and increasing their risk of disease contraction. A law in place in Botswana states, "If a woman is to marry under either general or customary law, she becomes subject to her husband's authority in financial and property matters and women may not open a bank account or business without the permission of her husband" (Keene, 2001, p. 66). Also,

while male infidelity is not adequate grounds for a divorce, female infidelity is in fact considered adequate grounds for a divorce (Keene, 2001). Even in the cases where women do divorce their husbands, it is often the case that the financial assets go primarily to the man, leaving the woman in a very vulnerable financial situation. Theoretically, the financial burden placed on divorced women could hinder victims of domestic abuse of infidelity from seeking divorces. Married men having multiple sex partners being culturally and legally acceptable of course puts all women at risk for STD contraction.

Contrarily, in Uganda, infidelity is considered adequate grounds for divorce for both men and women. This was not always the case in Uganda. However, with the help of a women's rights group, Law and Advocacy for Women in Uganda, now "husbands and wives are equal before the laws of adultery" (Women's ENews, 2007). This law is not only an important step for women's rights, but it is also an important step for lowering HIV rates. Research has indicated that women face a huge risk of HIV infection from their husband's extramarital activities (Parikh, 2007). This may be observed because "[w]omen who are economically and socially dependent on their husbands or lovers have difficulty negotiating condom use and inquiring about their partners' extramarital liaisons" (Parikh, 2007, p. 1198). Men having the legal right to have multiple sex partners in Botswana puts their wives and other sex partners at high risk of disease infection.

A bride price is very common in many countries particularly in Africa. A bride price is some sum of money or a quantity of goods that a man gives to the family of the woman he wants to marry. The bride price is meant to symbolize the man's commitment to the wife, and a respectful way to uphold culture and tradition (BBC, 2015). However, an issue with the bride price concept is that in the case of divorce many men demand the return of their bride price. This

often puts the bride and her family in a very difficult position of re-accumulating funds, which sometimes may be a nearly impossible feat. Sometimes, the bride price return even forced women in unhealthy relationships to stay with abusive partners. Evelyn Schiller, the director of Mifumi, one of the many NGOs advocating for women's rights in Uganda stated, "when married women who are abused complain, they are reminded about the property that was given to their parents and may feel compelled to stay if their parents are unable to pay back the bride price they received" (The Guardian, 2015). Women who have received a bride price may therefore feel obligated to stay with an unfaithful or sexually abusive man, therefore increasing their risk of HIV infection.

In 2015, the Ugandan court ruled it illegal to demand the return of the bride price after divorce. Justice Bart Katureebe, who was one of the six judges that agreed on the ruling stated "The return of [the] bride price connotes that the woman in marriage was some sort of loan. But even in sale, the cliche is that goods once sold cannot be returned or goods once used cannot be refunded. If that cannot be done in respect to common goods like cows, why should it be applied to a woman in marriage?" (The Guardian, 2015). In many countries within the region, including Botswana, laws of this nature intended to protect the rights of women have yet to be passed. This sort of forward thinking speaks volumes about the state of women's right in Uganda and the potential for further strides towards gender equality in the future.

Sexual violence

Violence against women, primarily rape, has been a major problem in Botswana. Rape puts women at risk of HIV contraction by taking from them the choice to engage in safe sex.

Very few rapists are actually arrested or convicted for their crimes in Botswana. In 2011, The Gender Based Violence Study released that 28.9% of women in Botswana over the age of 18 had "experienced at least one episode of sexual violence in their lifetime" (National AIDS Coordinating Agency, 2013). Many victims of rape endure the assault in their own homes, with their own husband or significant other as the perpetrator; and this sort of rape often goes ignored in statistics concerning sexual violence. However, a cultural belief commonly held is that as a wife, it is one's obligation to give into a husband's request for sex, regardless or whether the wife wants to engage in sexual behavior or not (Keene, 2001).

A study conducted of 1138 people in 23 Botswana villages indicated that 68% of those surveyed did not know of or understand "defilement" (Freedom House, 2013). In 2008, the Botswana Police Report indicated that from January until July, there had been "over 600 cases of sexual abuse and violence among women and girl children" (Teitelman et al, 2009). While extensive data is available regarding reported sexual violence in Botswana, there is presumably a very large unquantifiable amount of unreported cases.

Sexual violence is far more prominent in Botswana than in Uganda. In a study determining the rape rate per 100,000 population in 105 countries, Botswana had the second highest rape rate in 2010 after South Africa. Per 100,000 population, Botswana had 92.9 reported rape cases (United Nations Office on Drugs and Crime, 2010). Uganda does not appear until much further down the list with 22.6 reported rape cases per 100,000 population. While these statistics do not include unreported rape cases, this massive difference is extremely significant. While several cultural and economic factors may be responsible for the huge amount of sexual violence in Botswana, rape within the nation contributes to the preexisting massive public health issues, by denying women their choice to engage in safe sex practices.

Conversely, in Uganda, female parliamentarians and groups have been extremely adamant and useful in the passing of laws criminalizing domestic violence. In 2013, the Ugandan police reported registering over 1,000 rape cases, the sentences for which are either life inprisonment or the death penalty (United States Department of State, 2014). The Ugandan government confronted the issues of rape and domestic violence, and through legislature and harsh punishments, have been able to spread awareness and arrest criminals.

Stigma around HIV/AIDS and a lack of understanding

In Botswana, a combination of fear and a lack of understanding surrounding the HIV virus has been responsible for breeding a stigmatized perception of HIV positive individuals. The idea of HIV/AIDS positive people being stigmatized in Botswana was tested through interviews conducted with 112 HIV/AIDS patients receiving antiretroviral treatment. The authors found that "Forty percent of patients stated that they delayed getting tested for HIV; 51% of these cited fear of a positive test result as the primary reason for delay" (Wolfe et al, 2006, p. 932). Not only are people fearful of positive results, but once one obtains a positive result, it is common to fear communication with others regarding the diagnosis. Denying and ignoring the dangerous realities of HIV for fear of stigmatization places people far more at risk of transmitting the disease.

A portion of the stigma against those who are HIV positive stems from a general civilian lack of understanding about how the disease functions and is transmitted. The Botswana AIDS Impact Survey interviewed 4,500 civilians in Botswana, and the results displayed that many Botswana citizens have very little understanding of how the disease is transmitted. Of those surveyed, 60% claimed that they would not buy food from a storekeeper who they knew was

HIV positive. The survey also deduced that 11% of those surveyed said they would be unwilling to take care of a family member who was HIV positive (Letamo, 2003). HIV is only transmitted by infected blood, sexual fluids, or breast milk that come in contact with a mucous membrane, enters the body via injection, or through damaged tissues (CDC, 2015). Therefore, any refusal to care for an HIV infected person out of fear of contraction is extremely unfounded and demonstrates a complete lack of knowledge surrounding HIV.

There is a strong correlation between a lack of understanding of HIV and one's chances of contraction (Letamo, 2003). Letamo surveyed males and females between the ages of 10-64. The survey entailed just seven simply posed 'yes' or 'no' questions asking about transmission and HIV contraction. Letamo concludes, "this study found a statistically significant association between lack of understanding that it is possible to reduce one's chance of HIV infection and having misconceptions about HIV transmission and prevention" (Letamo, 2003, p. 197). Displaying a lack of understanding surrounding both reducing risk of infection and misconceptions about transmission, "may not only encourage people to engage in high-risk sexual behaviour but may also help disseminate negative attitudes towards people with HIV" (Letamo, 2003, p. 198). If individuals do not understand how HIV is contracted, engaging in safe sex to protect oneself from HIV would be rather difficult. Through this study, one may deduce that a lack of comprehension of HIV not only increases an individuals risk of contracting the disease, but also contributes to stigma against HIV infected people. As stated earlier in this section, this stigma also contributes to higher HIV/AIDS rates.

By contrast, studies indicate that the Ugandan population as a whole has a relatively comprehensive knowledge about HIV. The Ugandan government and people reacted quickly as the epidemic began. President Museveni came into power in 1986, after fifteen long years of

dictatorship in the nation. Museveni was far more willing to assist in the creation of a strong civil society, and assisted in the creation of groups such as TASO; The AIDS Support Organization (Keene, 2001). Treatment plans and open discussions were promoted nationally, and information spread rapidly. In 1992, Uganda's HIV infection rate was about 16%, and by 2003 this percentage fell to about 4% (Keene, 2001). A study interviewed 1,781 individuals in Northern Uganda in an attempt to uncover if people were well informed about where they could go to protect themselves from HIV. The study concluded that, "[o]ut of the respondents, 86% knew of a site providing HIV testing, 64% had ever tested for HIV and 76% knew of a condom distribution outlet" (Sera, 2010, p. 29). These statistics do not solely demonstrate an understanding of HIV prevention, but also demonstrate Uganda's success in providing the essential resources for people to protect themselves.

Many studies also indicate that Ugandans have made major behavioral changes to protect themselves from HIV. *Science* magazine stated, "Uganda has shown a 70% decline in HIV prevalence since the early 1990s, linked to a 60% reduction in casual sex. The response in Uganda appears to be distinctively associated with communication about acquired immunodeficiency syndrome (AIDS) through social networks" (Stoneburner, Low-Beer, 2004, p. 714). In the mid-2000s, Ugandans had significantly less casual sex than individuals in countries such as Malawi and Kenya. The most commonly used slogan used in promoting safe sexual behavior is referred to as the ABC model- standing for abstinence, be faithful, and condomize. This would seem to indicate that the ABC model (abstain, be faithful, condomize) worked well in Uganda (Stoneburner, Low-Beer, 2004).

In the late 1980s, as stated previously, Botswana was slow to act on the HIV/AIDS epidemic. Eventually, a year long national emergency program was launched. The World Health

Organization, USAID and other non-governmental organizations around the world teamed up with the Ministry of Health in order to "promote changes in sexual behavior" (Opiyo-Omolo, 2004, p.1144). Despite these efforts, by the 1990s, most had abandoned the initiative and public discussion fizzled out as the program was not generating much success. The slogans and campaigns intended to spread knowledge about HIV/AIDS instead spread skepticism and even disbelief among certain people (Allen, Heald, 2004).

Conversely, Ugandan citizens were not skeptical of the campaigns involving increased HIV/AIDS rates and how to protect oneself from the disease. Uganda had had public health issues prior to the HIV/AIDS outbreak in the late 80's. A disease called "Slim" had been relatively deadly in southwest Uganda (Opiyo-Omolo, 2004, p.1148). It was later determined that Slim was in fact the HIV virus, however this was unknown to Ugandan people at the time. People referred to this mysterious illness as Slim because of its "emaciating effect on its victims" (World Bank, 2013). Therefore, once word of the dangers of HIV spread, Ugandan citizens were much quicker to believe these campaigns and attempt to protect themselves after seeing how damaging a public health epidemic can truly be.

Further studies have also been conducted demonstrating a link between exposure to media campaigns and safer sex in Uganda. From a superficial viewpoint, it may seem like basic common sense that individuals who are exposed to the dangers of HIV and methods of prevention would of course be more likely to engage in safer sex, but this is not necessarily the case. At times people will entirely dismiss media campaigns promoting HIV awareness, finding them offensive or irrelevant. A major component of HIV awareness campaigns in Uganda has involved behavior change, such as encouraging individuals to stop engaging in risky sex (meaning sex without a condom or sex with multiple or unfamiliar partners). In Uganda, it was

determined that "BCC [behavior change communication] exposure was strongly associated with higher condom knowledge: women and men who reported being exposed to messages in the mass media were at least twice as likely as those with no exposure to know of condoms as a mean to avoid HIV/AIDS" (Kirungi et al, 2006). In Uganda, a local city councilman who sold condoms to fisherman and local women said that condoms were "selling like hot-cakes" (Allen, Heald, 2004, p.1149). This statistic not only demonstrates that BCC campaigns were successful in spreading essential information, but that they were exponentially helpful in promoting safe sex.

Conversely, HIV awareness campaigns in Botswana were not nearly as well received. As many safe sex promotional campaigns emerged in Botswana, many of them promoted condom usage as well, and we observed a generally negative reaction. Botswana citizens thought of condoms as disgusting and even unnatural. In Botswana, "condom promotion seemed to encourage 'immorality'" (Allen, Heald, 2004, p. 1141). Botswana citizens seemed to believe that condoms promoted disloyalty and adultery, and condom usage was therefore seen as shameful.

Another reason cited for the campaign failures was that "[m]any were also offended by the campaign. In Botswana there is a deep- seated unwillingness to talk openly about sex, partly due to rules of respect that lie at the heart of family and kinship structures, which limit communication across generation and sexual divides" (Allen, Heald, p. 1144). In order for these sorts of campaigns to work, the groups initiating the campaign must really understand the culture and beliefs of their intended audience. In Botswana, the slogan became "[a]voiding AIDS is as easy as ABC- abstain, be faithful, and condomise". This slogan was commonly used in other Anglophone countries as well, as well as in Uganda as stated above, not solely in Botswana. However, in Botswana, citizens considered this slogan to be more offensive than helpful. Instead

of inspiring people to have safe sex, this campaign inspired people to ignore further HIV/AIDS awareness proposals (Allen, Heald, 2004).

Botswana is not a rare outlier; as exposure to media campaigns promoting safe sex was also unhelpful in countries such as Côte d'Ivoire and Zambia (Kirungi et al, 2006). This would seem to indicate that cultural differences must play a role in the success of HIV awareness media campaigns. Ugandan culture responded very well to the ABC model, but perhaps a different disease prevention model would have worked better in Botswana.

Lack of Sex Education

Presently, the youth have been big contributors to the HIV rate in Botswana. In recent years, changes in sex culture within the youth demographic in Botswana have had huge effects on sexual health disease transmission. In terms of government involvement in the HIV issue, "Botswana has no policy on sex education" (Opiyo-Omolo, 2004, p. 91). This is not surprising given the general "taboo" nature of sex in Botswana culture. This is in large part due to cultural norms regarding sex education between a parent and their child. In Botswana, it is often the case "that parents are uncomfortable talking about sexuality with their children" (Opiyo-Omolo, p. 91). While in many cultures parents are uncomfortable discussing sex with their children, in Botswana it seems many believe that these sorts of conversations between parents and children are even inappropriate.

Because the youth demographic is at a high risk of HIV transmission and contraction, studies attempting to determine the youth's comprehension of HIV transmission have been conducted in both Uganda and Botswana. The results indicate that Ugandan youth are much

more aware of how HIV is transmitted than the same age demographic in Botswana. Of 1, 781 young people in Uganda surveyed, 51% knew the three main ways of preventing HIV and 29% had a comprehensive understanding on HIV transmission" (Cicciò, Sera, 2010). These figures may seem low, but are actually high relative to Botswana. In Botswana in 2010, only 43.7% of surveyed youth were able to correctly identify ways of HIV transmission (UNAIDS, 2013).

In the past, strong societal norms encouraged unmarried youth to stay away from premarital sex (Opiyo-Omolo, 2004). The youth knew that having premarital sex would be shameful, and dishonor themselves and their families. However, we see now that youth pregnancy rates are at 19% and the average woman in Botswana has her first child at 18 (Opiyo-Omolo, 2004). Teen pregnancy has not been the only ramification of increased sexual activeness in Botswana youth. Opiyo-Omolo states, "[t]he HIV/ AIDS prevalence rates point to the fact that up to 15% of all HIV-infected persons are in the age cohort 15 to 19 years" (Opiyo-Omolo, p. 91). Because Botswana has no implemented sex education programs and these youth are uneducated, this demographic having unsafe sex has made major contributions to the HIV/AIDS infection rate.

Conversely, in Uganda, once President Museveni was presented with the risk that HIV posed to population growth, he "ordered the military to hold mandatory sex education classes with condom demonstrations" (Grundfest Schoepf, 2003, p. 561). In the mid-90s, a program entitled *Young Talk* was launched providing "comprehensive information about sexual and reproductive health" (Grundfest Schoepf, 2003, p. 561) to children between the ages of ten and fourteen. The program then reported back to the Minister of Education. By aiming newsletters at young people, these children were able to obtain the necessary information to protect themselves

before they were sexually active. Education campaigns of this sort are able to protect people before they are even at risk, providing these individuals with the necessary tools to engage in safe sexual behavior once they are sexually active.

Negative stigma surrounding condom usage are prominent in Botswana, specifically in the youth demographic. Scholars have attempted to uncover why youth may abstain from using condoms despite their availability. The study determined that many young women fear that by buying condoms, they could be mistaken for prostitutes. Teens also worry that if they are seen buying condoms, someone could inform their parents that they are sexually active (Meekers, Molatlhegi, 2001). Though it is not unreasonable to assume that adolescents wanting to hide their sex lives from their parents is a global phenomenon, it is essential to consider the forbidden and illicit nature of youth sex as discussed earlier in this paper. Therefore, while teenagers probably feel nervous buying condoms despite their nationality, Botswana teenagers feel they are deviating from a social norm in a much more extreme sense than a teenager elsewhere.

Strong cultural norms regarding young women and sexuality are also present in Uganda, however these norms may have actually created a positive effect in terms of tackling the HIV epidemic. Traditionally, the role of the *senga* is extraordinarily important in Ugandan culture. A *senga*, or a young woman's aunt on her father's side, serves a very significant role in the young woman's life. A *senga*'s duty is to " socializ[e] adolescent girls into sex and marriage among many ethnic groups in Uganda" (Muyinda et al, 2001). Culturally, it is often considered inappropriate or uncomfortable for an adolescent to talk to their parents about sex. Therefore, the *senga* serves as a sort of female father (Muyinda et al, 2001). Over time in Uganda, the meaning of the word *senga* has broadened. While these women were once relatives who provided their nieces with relationship advice and insight on becoming a woman, the *senga* now also

encompasses "places where sexual knowledge can be obtained, such as senior women's offices in schools, AIDS counsellors' offices and church marriage counsellors' offices" (Muyinda et all, 2001, p.70).

The usage of a traditional term to explain more modern forms of health provision provides a familiarity for Ugandan women who chose to seek help from these newer and more progressive options. The inclusion of councilors and health professionals in the term *senga* bridges the contemporary and the traditional. This inclusion allows individuals to maintain their customary practices while still encouraging individuals to seek professional help.

Government Initiatives and their cultural responses

An effective way for men to protect themselves and others from HIV is through circumcision. Male circumcision is known to reduce the risk of HIV/AIDS transmission. This is because circumcised men have much fewer bacteria on their genitalia. It was found that "[circumcised men] ... had 81% less bacteria overall compared to the uncircumcised men, and that could have a dramatic effect on the men's ability to fight off infections like HIV" (Liu et al, 2013). It is also observed that circumcised men can be up to half as likely to transmit HIV (Liu et al, 2013). Groups within both Uganda and Botswana have been working towards encouraging more men to get circumcised for this reason. However, Uganda has seen much more success through various pro-circumcision programs than Botswana.

The Botswana government launched an initiative entitled the Safe Male Circumcision in 2009. NGOs, US government agencies, and the Botswana Ministry of Health have collaborated on the initiative in hopes of encouraging Botswana society to practice safe male circumcision. The group has conducted several media campaigns using celebrities to gain traction, but has been

unable to attain the desired progress. Circumcision is relatively common in Botswana, but is viewed as a component of a traditional coming of age ceremony. Traditionally, men would be taken to wooded areas as a large group where they would undergo circumcision together as a bonding experience and a way to display masculinity (Meissner, Buso, 2007). Despite this practice being seen as barbaric by certain groups within the country, many ethnic groups continue these sorts of circumcision practices as a way of preserving tradition. Therefore, the introduction of hospitalized medical circumcisions was at a time a very new concept in Botswana. Clinics have been set up around the country in order to encourage men to become circumcised by doctors in hygienic and sanitary conditions (Katisi, Daniel, 2015). Though these clinics and media initiatives have had some success in convincing men to become safely circumcised, only 39% of the annual goal in 2012 was circumcised (Katisi, Daniel, 2015). Though at a glance this government program seems as though it could be very beneficial in lowering HIV transmission rates, from a cultural perspective this initiative can be viewed as a threat to important traditions, rendering it less successful.

In Uganda, similar male circumcision promotional efforts have been made. In 2011, the Ugandan Ministry of Health launched an initiative entitled “Stand Proud, Get Circumcised”. This organization encourages men to practice safe circumcision, and aims to encourage women to support their men to get circumcised. In a study conducted in 2009 by the Uganda Health Communication Partnership, most men who planned on getting circumcised stated the main reason was to reduce their risk of HIV (K4 Health, 2009). This demonstrates an understanding of the HIV virus, and an apparent public knowledge of how to protect oneself. As of March 2012,

“Stand Proud, Get Circumcised” had been responsible for 1.5 million circumcisions in Uganda (Washington Post) just a year after being introduced.

“Stand Proud, Get Circumcised” uses an interesting advertising model that has seemed to be successful in encouraging safe male circumcision (SMC). The campaign uses a, “unique and provocative approach to convince men to act. It speaks to men through women” (Johns Hopkins Health Communication Partnership, 2011). The campaign also aims to show men that the procedure is not painful, after studies indicated that the main reason Ugandan men gave for not wanting to get circumcised was fear of pain (Johns Hopkins Health Communication Partnership, 2011), and aims to show men where they can go to get an SMC. As a result of this clever and effective campaign, “Uncircumcised males who were exposed to Stand Proud, Get Circumcised were 60% more likely than their unexposed counterparts to intend to get circumcised in the next 12 months and three times more likely than those who were not exposed to know that male circumcision reduces HIV, two times more likely to state that male circumcision is beneficial and two times more likely to discuss male circumcision with others” (USAID, 2012).

Argument: Income Inequality

From a surface level, Botswana is a much wealthier country than Uganda. Botswana's GDP is 7,315 US dollars per capita; whereas Uganda has a significantly lower GDP per capita of 571 US dollars. However, other metrics must be considered when doing an economic comparison of the two nations. A useful metric for this comparison is the Gini coefficient. The Gini aims to quantify the economic inequality within a country. The coefficient falls between 0 and 1; 0 being perfect equality and 1 being perfect inequality. In 2012, the World Bank reported that Uganda had a Gini coefficient of .42 (World Bank, 2012). In contrast, the IMF reported in that same year that Botswana had a Gini coefficient of about .5, which was described as being "one of the highest in the world especially when compared with other high middle-income countries" (IMF, 2012). Therefore, despite Uganda's lower GDP, it has less income inequality than Botswana.

Additionally, by analyzing the Gini coefficients of the nations with the highest HIV rates in sub-Saharan Africa, one may deduce that "Southern African countries with high HIV prevalence all share a common trait—they are among the most unequal countries in the world" (Fox, 20). After controlling for several other factors, studies determined that "national income inequality is significantly positively correlated with HIV/AIDS levels (Fox, 2010, p. 21)".

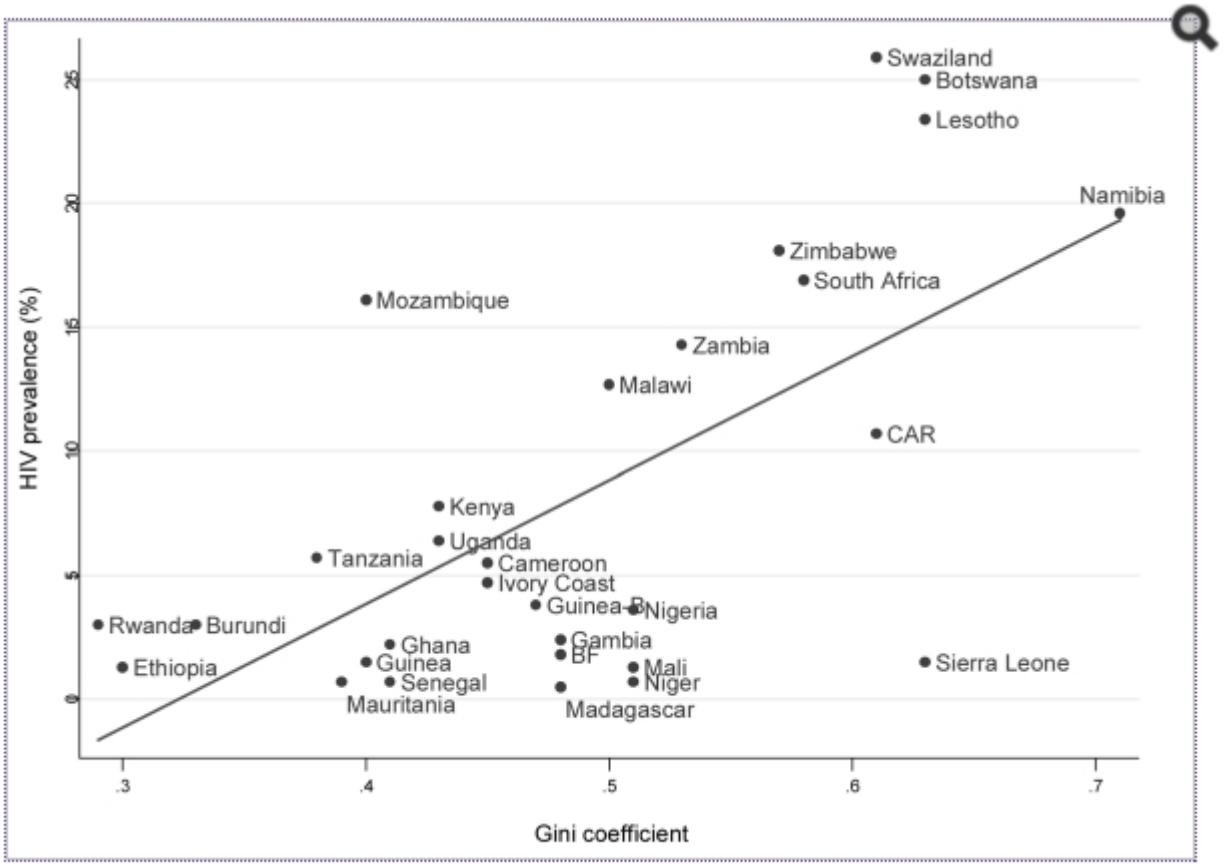
Africa is one of the most economically unequal regions of the world (Okojie, Shimeles, 2006). This income inequality in the region is further exacerbated in many nations between men and women. In order to fully comprehend the following section of this analysis, it is necessary to make a clear differentiation between general poverty and income inequality. The poverty rate is a statistic measuring the specific number of people whose income falls below an established

poverty line. Income inequality attempts to measure where the income in a nation is concentrated, or the wealth gap between the rich and the poor within a population. In countries with little economic inequality, prosperity is more broadly distributed, as opposed to in economically unequal countries where most of the nation's prosperity is concentrated within a small portion of the population.

In economically unequal countries we observe relative poverty, meaning "a situation where people's basic needs have been met, but relative to other individuals, they have fewer resources" (Fox, 2010, p.22). While relative poverty is observed everywhere, it may be exacerbated in middle income countries (like Botswana), and in high income countries. Relative poverty is very different from absolute poverty. Those living in absolute poverty would be those who lack the essential means of survival such as nutrients and access to sanitary conditions. By making this distinction, we can then state that what really contributes to HIV in a nation is relative poverty, not absolute poverty (Fox, 2010).

Within sub-Saharan Africa, the Gini coefficient seems to be a very useful predictor of HIV prevalence in a nation. There is a very clear and observable positive correlation between the two variables. A study determined that "even after controlling for an array of covariates, wealthier individuals were still more likely to be HIV-positive than poorer individuals" (Mishra et al, 2007, p. S17) within eight sub-Saharan African nations studied. Countries such as South Africa, Swaziland, and Botswana- with the highest HIV rates in the region, also tend to be the most economically unequal. By gross national income (GNI) based on purchasing power parity (PPP), we are able to compare the HIV rates of many African countries and determine how the Gini coefficient within a country might affect those HIV rates.

The scatter plot below does not demonstrate causation, solely correlation. One must consider the limitations of a bivariate plot, as other variables could perhaps explain this correlation. However, the data is at the very least suggestive[2].



[2] (Fox, 2010)

Economic Inequality by Gender

It appears that we observe less economic gender inequality in Uganda than in Botswana. The Gender Development Index measures inequalities in four major categories; reproductive health, which is measured by mortality ratios and teenage birth rates (United Nations Human Development Reports, 2015). It also measures "empowerment", or the percentage of parliamentary seats that are occupied by women in a specific country. It also measures economic status, which takes into account various factors such as labor force participation rates by gender (United Nations Human Development Reports, 2015), and lastly measures education gaps between men and women. The World Economic Forum created a gender gap index rating in 2013 of 136 countries. Uganda ranked as the 37th most equal country of the 136, whereas Botswana ranked substantially lower at number 48 (World Economic Forum, 2013). The World Economic Forum also scored these same 136 nations with a "political empowerment ranking" for women. Uganda ranked highly, at number 28. Botswana received a rating of 127 (World Economic Forum, 2013). These results have been very similar overtime. In 2006 the Economic World Forum political empowerment ranking did not differ much from the 2013 rankings; with Botswana at number 47 and Uganda at number 22 (World Economic Forum, 2006).

A major reason for Botswana's low rating is that women are immediately faced with a disadvantage as they start school compared to their male counterparts. From 2008-2012, the gross enrollment ratio for primary school for girls was about 4% lower than the enrollment ratio for boys during those years (Unicef, 2013). Because women are 4% less likely than men to enroll in primary school, they are less likely to obtain the educational tools one would need to be successful in the workforce. In Uganda, the enrollment ratio for primary school for girls was only 2% lower than for boys during the same timeframe (Unicef, 2013).

Because women play a much more active role in politics and in the work force in Uganda, they would generally be less economically dependent on men for basic needs or for luxury goods. Women's subordinate economic status in Botswana creates a culture of financial dependence on men, risking their sexual health.

Transactional sex

Because women are typically dependent upon the financial assistance of men in Botswana, a societal issue of young women engaging in transactional sex is prominent. Transactional sex describes men or women who engage in sexual relationships with others in exchange for various gifts or money. In the case of Botswana, these relationships are often intergenerational and involve a young woman seeking an older man.

While the Gini coefficient measures domestic income inequality, in order to argue that transactional sex is a result of income inequality between men and women, one must also look at between-group inequality between men and women. In Botswana, "men [are] substantially more likely than women to be: (i) craft and related workers; (ii) self-employed without employees; (iii) self-employed with employees; (iv) legislature/managerial and professional workers; (v) agricultural workers; and (vi) paid workers" (Ncube, 2011, p. 25), and they are far less likely to be involved in unpaid family work or clerical occupations (Ncube, 2011). The most high-skilled sorts of professions demonstrate the largest gender gap, such as "legislature/managerial, and professional occupations" (Ncube 2011, p. 26). Therefore, there are far less women than men involved in private business. Even of the women who are involved in private business, "women experienced a 37% pay gap" (Wage Indicator, 2009). Because women are far less likely than

men to be involved in the professional workforce, they may feel reliant upon men for financial stability.

Economic reliance upon men has created a "sugar daddy phenomenon" in Botswana. The sugar daddy relationship describes intergenerational couples, when the male is at least ten years older than the woman; and age-disparate relationships, when the male is at least five years older than the woman (Leclerc-Madlala, 2008). Relationships of these sorts have become common in Botswana and other nations with severe income inequality. Of girls who were having sex with older men, 79 percent agreed with the statement that: "[t]he reason girls go out with older men is that they are able to provide gifts and money" (Nkosana, 2007). Young women seek out an older and more established man who can seemingly provide them with financial comfort and support. Because young women may feel that they are incapable of economic upward mobility on their own, they can feel reliant upon a male for the prospect of financial comfort. These relationships put younger women at risk of HIV contraction for many reasons.

The probability that a couple will engage in unprotected sex increases exponentially in sugar daddy relationships, such that "for every year's increase in the age difference between the partners, there was a 28% increase in the odds of having unprotected sex" (Leclerc-Madlala, 2008, S18). Culturally, these couples tend to view each other as being low risk sexual partners. The man will often view the young woman as being pure and innocent, while the woman views the man as being mature and responsible (Leclerc-Madlala, 2008). A study conducted by UNICEF in which girls between the ages of 13 and 16 were interviewed concluded that, "34% of the students said they had sex for money, gifts or favours and of those sexually active, 48% said they had never used a condom" (USAID, 2002).

Individuals in sugar daddy relationships are also less likely to use condoms because the women may fear "that they often cannot insist on safe sex practices, and doing so would jeopardize their economic goals in the relationship" (Leclerc-Madlala, 2008, S18). Young women in sugar daddy relationships have a particular vested interest in satisfying the wants of their significant other, and will therefore potentially engage in unsafe sex practices.

The sugar daddy phenomenon also puts women at risk from a biological perspective. As stated earlier in this paper, women face more biological risk of HIV contraction. While all women are more susceptible than men, young women are especially susceptible to HIV. This is because "the genital tract of young girls is immature and more prone to invasion by HIV (Rwanda News Agency, 2010)". As indicated, "15–19-year-old African women [are] many times more likely to be infected than their same-age male peers" (Wyrod et al, 2011, p. 1275). Because girls engaging in sugar daddy relationships are typically young and perhaps underdeveloped, their risk of HIV is even further exacerbated.

A common assumption that is not necessarily true is that these young women are seeking basic needs for survival. This is often not the case. Because of the large wealth gap in Botswana, many of these sugar daddies are able to provide things like "designer clothes, the latest cell phones and glitzy cars" (Leclerc-Madlala, S21). The sugar daddy phenomenon is also at times referred to as "the 3-Cs boyfriend"; meaning the boyfriend provides the woman with cash, cars, and cell phones (Fox, 2010). Both of these contemporary sayings (sugar daddies and 3-Cs boyfriends) indicate how the goals of transactional sex are very different in countries with high GPPs. The sugar daddy phenomenon is most commonly studied in Botswana and South Africa because of the large percentage of relatively wealthy men in these nations, and the large percentage of women who are unable to attain this level of wealth on their own. Wealthy men

developed an initial risk of HIV infection "from their relative prestige and power, which allowed [them] to seek out and gain multiple sexual partners, and women (whether initially wealthy or not) to benefit financially from their liaisons with well-off men" (Fox, 2010, p. 22). These wealthy men are then the ones often engaging in intergenerational sex, and they are potentially posing a threat of HIV to multiple sex partners.

In a nation like Uganda where the income gap is smaller, women tend to rely much less on a sugar daddy, as wealth is distributed more evenly and GDP per capita is much lower. Uganda's classification as a low income country would indicate that more Ugandans struggle with absolute poverty than with relative poverty. Therefore, because Ugandan men generally would be financially unable to provide cash, cars, or cell phones, it is only rational to assume that women would not expect a man to provide them with these things, and therefore be less likely to seek a sugar daddy or 3-Cs boyfriend.

Dismissing Counterarguments

In the following section, I will dismiss certain counterarguments that are commonly argued to contribute to high HIV rates in sub-Saharan Africa and generally. While in other contexts, the following counterarguments may very well be true, I will argue that in the specific cased of HIV in Botswana and Uganda these schools of thought are inapplicable. In the comparative case study of Botswana and Uganda, I argue that one cannot attribute the biology of the virus, stigma and laws against homosexuality, or general poverty to high HIV rates in Botswana and low HIV rates in Uganda.

Biology

Many scholars have argued and investigated the idea that different subtypes of HIV might have different transmission rates, which could potentially explain why certain regions of the world face a much more severe HIV epidemic than others. However, while different strains may have different pathogenicities, I argue that this logic cannot be applied in the case of high HIV rates in sub-Saharan Africa. There are many subtypes of HIV found in different geographic locations. The two strains of HIV are HIV-1 and HIV-2. HIV-1 is by far the more common of the two, and HIV-2 is relatively uncommon and seen primarily in West Africa. HIV-2 has been discovered to be less infectious and to progress at a slower rate than HIV-1 (Avert, 2013). It is also more closely related to SIV (discussed earlier in the paper) than HIV-1.

HIV-1 is divided into four sub-strains entitled Groups M, N, O, and P. Group M is the predominant group and is responsible for the bulk of the HIV epidemic. Groups N, O, and P are extremely rare; group N being the most common of the three with only 13 cases documented all

in Cameroon (Klatt, 2002, p. 8). Group M is then divided up into nine subtypes, called A-K. The sub-strain present in Southern Africa is subtype C. By the 2000s, subtype C was responsible for more than half of all HIV infections worldwide (Iliffe, 2006). This led many to believe that subtype C perhaps "had greater evolutionary fitness than other subtypes" (Iliffe, 2006, p. 37). However, "no conclusive evidence of this had emerged by 2005" (Iliffe, 2006, p. 37). It has been deduced that antiretrovirals (ARVs), which were developed mainly in relation to subtype B, which is most prominent in the Americas and Australia, are effective in treating multiple strains of HIV/AIDS including subtype C (Avert, 2013).

The question of different strains having different rates of transmission and rates of progression has been tested by many medical professionals and results have often been conflicting. The topic remains highly debated by scholars and medical professionals. However, currently there is no reason to deduce that subtype C is any more or less easily transmittable than any other strain. The only strain that has been proven to have a higher pathogenicity is subtype D, primarily found in Cuba (Gatell, 2011). Therefore, I conclude that the strain of HIV in Southern Africa is no more contagious nor deadly than any other strain, indicating that other factors must serve as the explanations for why the HIV epidemic is so devastating in Botswana particularly.

The most prominent strain of HIV in Uganda is subtype A, infecting 48% of HIV victims in the state (CDC, 2015). Because subtype B is the most common in the global North in locations such as North America, Australia, and Western Europe, the majority of ARV research has been conducted with regard to this subtype specifically. Regardless, it has been deduced that "modern antiretroviral therapy works well for the handful of non–subtype B viruses investigated so far

and will certainly save lives, independent of the subtype of the infecting virus" (Pond et al, 2009, p.3).

Many doctors have attempted to answer the question: are antiretrovirals equally as effective in treating non-subtype B strains as they are at treating subtype B? All ARV therapy was created on the basis of treating subtype B, despite the fact that subtype B only accounts for 12% of HIV infections globally (Pond, Smith, 2009). Yet despite assumptions and theories that these ARVs might be less effective at treating non-B strains, the opposite seems to be true. A study was conducted treating 2116 patients who were infected with subtypes A-D with standard ARV therapy (Geretti et al., 2006) The study found that 90% of the patients were able to achieve a decreased viral load through ARV therapy. In fact, the doctors observed that the viral load was "suppressed more rapidly" in patients suffering from subtype C than any other strain (Geretti et al, 2006, p.1296). With a suppressed viral load, disease transmission between sexual partners is far less likely. In fact, it has been determined that early HIV treatment reduces the risk of HIV transmission by 96% (Eshleman S, 2005).

This would seem to indicate that subtype C is actually more easily suppressed than other subtypes. Therefore indicating that subtype C doesn't have a worse pathogenicity than other strains. Some may assume that because HIV rates are so high in Southern Africa that the particular subtype must be harder to treat and easier to contract, but this has yet to be proven scientifically.

General Poverty

For decades, many have argued that poor countries are more at risk of a severe HIV epidemic, however I argue that it is not absolute poverty that correlates to high HIV rates. It is

easy to imagine why some may guess that this positive correlation exists by assuming that individuals in poorer countries have less access to a proper health care system and to an adequate treatment plan. The region of the world with the highest concentration of HIV is sub-Saharan Africa, which is a region also notorious for economic struggle. Many studies have been published establishing a link between national poverty, meaning a nation's GDP and their HIV rates. In 2001, UNAIDS stated that "[p]overty, underdevelopment, the lack of choices and the inability to determine one's own destiny fuel the [HIV] epidemic" (UNAIDS, 2001). However, this assumption is far too simple and in recent years has come under scrutiny.

If it were the case that poorer people and poorer nations had higher HIV rates, we would expect to see that Uganda would have a much higher infection rate than Botswana, which is of course not the case. While many other variables must be considered in this specific case study, Botswana and Uganda are not nearly the only countries that raise issue with this previously assumed notion. In fact, recent data has indicated that perhaps there is even an inverse relationship between poverty and HIV rates. Evidence is becoming more and more apparent, at both the state and individual levels insinuating that wealthier nations and individuals within countries might actually be at heightened risk for HIV (Fox, 2010). When analyzing HIV in sub-Saharan Africa, the top three countries with the highest HIV prevalence are Swaziland, Botswana, and Lesotho. These three nations are nowhere near the poorest countries in sub-Saharan Africa; demonstrating that perhaps there is more to high HIV rates than just extreme poverty.

Evidence even seems to demonstrate that within specific nations, richer regions have disproportionately high HIV rates when compared to the poorer regions of the country (Fox,

2010, p.17). This phenomenon has become known as the "positive-wealth gradient in HIV infection" (Fox, 2010, p. 17). An explanation that is often cited as the reason for this positive wealth gradient is that certain risk factors for disease contraction increase with wealth. These factors include wealthier men and women having more access to multiple sex partners, and statistical finding that wealthier individuals in the region are more likely to engage in premarital sex (Fox, 2010).

Anti-homosexuality Laws And Stigmas

*S*tudies have been conducted involving the correlation between anti-homosexuality stigmas and high HIV/ AIDS rates for decades in developed countries. For example, scholars (Smith et al, 2009) argue that laws against homosexuality restrict the gay community's access to HIV/AIDS information and services. However, while perhaps seemingly illogical, I argue that there is no reason to conclude that laws against homosexuality affect HIV rates within a nation. Homosexual acts are illegal in 79 countries, 34 of which are in Africa, making homosexuality illegal in about 63% of African countries (Amnesty International, 2015) .

Men who have sex with other men (MSM) are much more likely to contract HIV than heterosexual couples for various reasons. According to the Centers for Disease Control, "Gay and bisexual men make up about 2% of the overall population, but account for approximately two-thirds of all new HIV infections each year [globally]" (CDC, 2015). Gay men face the highest risk of contracting HIV/AIDS in part because anal sex is "the riskiest type of sex for getting or transmitting HIV" (CDC, 2015). Because as a group, a larger percentage of gay and bisexual men are HIV positive, we are able to assume that gay and bisexual men also have a higher chance of being exposed to the virus (CDC, 2015).

Logically, if it were the case that countries with laws against homosexuality had higher HIV rates, we would expect to see that the 34 African countries with such laws in place would have some sort of correlation with higher HIV rates than the other 20 African countries with no such laws in place. This does not seem to be the case. Of all sub-Saharan African countries, Algeria has the lowest HIV rate with about 0.04% of the population infected (CIA The World Factbook, 2014). Algeria also has strict laws in place criminalizing homosexuality with jail time (Law Library of Congress, 2014). Tunisia also has an HIV infection rate of about 0.04% (CIA The World Factbook, 2014), and laws state that homosexual acts are punished with imprisonment for three years (Law Library of Congress, 2014)[3]. While other factors also would influence these statistics, there is no visible trend between countries with laws against homosexuality on the books and HIV rates.

In Botswana, any same-sex activity is entirely forbidden by law. The law does not specifically refer to homosexual acts as illegal, but instead outlaws "unnatural acts", which includes homosexuality (US Department of State, 2011). Same sex "acts" can be punishable by jail time or fines. Homosexuality is seen as being comparable to a "disease", and homosexual people are generally ostracized by their friends and families (Opiyo-Omolo, 2004, p. 89). Generally, citizens of Botswana see homosexuality and being "un-African" and see homosexuality as an American malady that is making its way around the globe (Opiyo-Omolo, 2004). The Deputy Speaker in the Botswana National Assembly, Pono Moatlhodi, once said that if he was granted the power he would have all homosexuals killed (LGBT Weekly, 2011). Many (Semugoma et al, 2012, Beyrer et al, 2012) have argued that laws against homosexuality breed

[3] Time series data involving enforcement of such laws and arrests made in each nation is unavailable.

stigma against homosexual people, leading gays to feel ostracized and engage in risky sexual behavior to avoid being outed.

However, a nation that is notorious globally for a strong stigma against the gay community is Uganda. Newsweek recently dubbed Uganda as being the second most homophobic country in the world. Uganda has been especially under scrutiny lately for their homophobic laws and views since passing new and more severe anti-homosexuality laws in 2014. In 2014, Uganda passed a bill entitled the Anti-Homosexuality Bill. In Uganda, homosexual acts were already forbidden, but this law intensified punishments and dramatized stigma. The Anti Homosexuality Bill made punishments for homosexual acts much harsher, including increased jail time and higher fines. This law specified that civilians who do not report homosexuals to the government and law officials are also guilty of breaking the law. In early drafts of this bill, certain homosexual acts were even punishable by death.

As stated earlier, Uganda's HIV rate is currently at 7.4%, which is higher than it has been in recent years. While the timing of these new laws along with the HIV rate rise may seem to be compelling evidence that laws against homosexuality might positively affect HIV rates, I argue that this is not the case. Uganda has seen an increase in HIV rates for an entirely different reason. Many in the public health field have "blamed Uganda's government for becoming complacent since winning international acclaim, and reams of financial aid, for its AIDS efforts" (New York Times, 2012). This would insinuate that because Uganda was so successful in confronting the epidemic in recent years through the initiatives and programs discussed throughout this paper, the fear surrounding the virus subsided.

One reason why anti-homosexuality laws do not play a large role in HIV rates despite the gay community being such an at risk group is that the laws are often very ineffective. Countries

with anti-homosexuality laws in place often make very few arrests (Amnesty International, 2013). Countries may struggle to convict someone of a homosexual crime because it may be very difficult to prove that someone is gay or to catch someone engaging in homosexual activity. It is frequently stated that "few cases have been taken to judgment" (Human Dignity Trust, 2015). In fact, from the years 2007 until 2011 the Human Rights Awareness and Promotion Forum, a Ugandan group that tracks cases against the gay community and provides "suspects" with legal defense reported that "they were aware of 23 arrests on the basis of same-sex conduct, none of which resulted in prosecutions" (Amnesty International, 2014). As stated previously, Uganda has a population of about 37.58 million people (World Bank, 2013). 23 arrests in four years of the 37.58 million citizens is insanely minuscule, and none of these 23 people were prosecuted.

A second reason I argue that we cannot draw the conclusion that laws against homosexuality contribute to high HIV rates in sub-Saharan Africa is that the necessary data to conclude this is nonexistent. Because of the large stigma against homosexuality in the region, studies surrounding the gay community can be inaccurate because most gay people would not want to admit that they are in fact gay. Most participants in studies on the link between homosexuality and HIV deny any same sex activity. As many continued to attempt to study this link, "researchers advised caution, citing insufficient data about homosexuality and anal intercourse, and the difficulty in gathering accurate behavioural information from African patients as caveats to the prevailing understanding of the epidemic" (Smith et al, 2009, p. 417). Therefore there is an obvious bias with studies that attempt to study stigma and laws against homosexuality, and how those affect sexual health of the gay community.

Homosexuality is illegal to some degree in most African countries- therefore the variation in HIV rates between countries must be attributed to other factors. There seems to be no visible

correlation when analyzing HIV rates within the region and comparing those with anti-gay laws. While there could potentially be some sort of correlation between stigma and laws against homosexuality and HIV rates, the research to make that conclusion does not exist at this point.

Conclusion

After extensive research, I have found strong and direct correlations between various cultural norms and economic disparities and the exorbitant HIV rate in Botswana. Through my analysis it is clear that several factors affect the HIV rate not solely in Botswana but generally. In order for Botswana to be able to successfully confront this massive public health epidemic, women must be empowered economically and socially. I conclude that the oppression of women and and their subordinate status in society are huge factors in explaining Botswana's HIV epidemic. This oppression is present in the professional, political, and social realms.

As observed through Uganda's political endeavors to empower women, engaging women in politics can be a huge step towards reducing the gender gap and sexism in a country. Not only do female politicians empower other women to pursue professional goals, but female politicians are also more invested in looking out for the rights and in demanding equality for other women. Female politicians in Uganda have been very useful in the creation of various programs and initiatives that protect the health of women, such as laws against domestic violence and female genital mutilation. These sorts of laws ensure that women are able to protect themselves and their sexual health.

The Ugandan government also provides married women with more legal rights than the Botswana government provides. Because women in Botswana are often financially dependent on their husbands, they may feel unable to divorce abusive or unfaithful husbands, therefore risking

their sexual health as their husbands have extramarital affairs. In Uganda, women can seek divorce without fear of extreme financial hardship. Perhaps if Botswana were to establish laws protecting the rights of the wife in a marriage, women would be more able to better protect themselves from the risk of HIV.

I also conclude that the stigma against HIV infected persons, as well as cultural perceptions towards youth sex education, play a huge roll in the country's inability to successfully manage the epidemic. Stigma towards HIV infected persons seems to stem from a lack of understanding surrounding the disease. This lack of understanding encompasses an inadequate comprehension concerning how transmission is possible, and how to protect oneself from the virus. Uganda's national efforts to educate the youth even before they are old enough to engage in dangerous sexual behavior sets the youth demographic up to make safe choices in the future. Botswana's policy of essentially shielding sexuality from the youth places young individuals in a position to make potentially unsafe and uneducated sexual decisions.

Awareness campaigns must also be tailored towards the specific audience at which they are directed. Safe sex campaigns can be construed as insensitive or culturally ineffective, therefore careful consideration must be employed before their implementation. The approach of implementing a media campaign that has been deemed successful in one country in others is not exactly a foolproof method. Though this conclusion may seem rather intuitive, public health campaigns that are effective in one culture will not necessarily be effective in another.

The following section of this paper addressed the economic inequality between genders that is extremely prominent in Botswana, and less prominent in Uganda. I concluded that economic inequality, particularly between genders, is an issue that is highly correlated with HIV rates in sub-Saharan Africa. Because women may feel incapable of upward mobility on their own

without the assistance of a man, they may make risky choices to ensure their financial stability.

Women engaging in transactional or intergenerational sex puts them at risk of disease contraction. Young girls and women are likely to engage in transactional sex and intergenerational relationships in exchange for luxury goods. This phenomenon has been perpetuated due to the cultural understanding that as a woman in Botswana, economic opportunities are limited. Because women will typically feel far less comfortable suggesting condom usage to older partners for fear of jeopardizing their goals in the relationship, HIV risk increases vastly. Moreover, it is common that the wealthier, older men engaging in such relationships have multiple sex partners, therefore potentially risking the health of many women. By empowering women and providing them with opportunities for financial comfort without the assistance of a man, women could become far less at risk for STD contraction in Botswana. Uganda has successfully created a role for women in politics which has been instrumental in the protection of their sexual health.

I argue throughout this paper that these are the main cultural and economic differences between Uganda and Botswana that explain why Botswana hasn't seen anywhere near the level of success as Uganda in confronting HIV. I argue that various arguments that are commonly made, such as the biology of the virus, general poverty, laws and stigma against homosexuality, are inapplicable in this particular case study, and even in sub-Saharan Africa generally. As Uganda continues to be a major success story in tackling the HIV epidemic, hopefully countries like Botswana will be gain an insight and understanding of how to address the major public health crisis occurring nationally.

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