ORIGINAL RESEARCH ARTICLE

Sterility and Stigma in an Era of HIV/AIDS: Narratives of Risk Assessment among Men and Women in Botswana

Rebecca L Upton[1*] *and Edward Myers Dolan*[2]

[1]DePauw University; [2]Centre for the Study of HIV/AIDS, University of Botswana, Botswana

***For correspondence:** *Email:* rupton@depauw.edu

Abstract

This paper examines the experience and interpretations of infertility and sterility in northern Botswana. Specifically it highlights the role of stigma and impression management among Tswana men and women through their narratives and discourse about childbearing and personhood in an era of HIV/AIDS. The paper demonstrates that in a country with one of the highest HIV/AIDS infection rates in the world, risky sexual practices are weighed against cultural norms that suggest being a full person and productive adult is to be a reproductive man or woman. Through longitudinal qualitative research the narratives and life histories of several individuals offer ethnographic evidence on the power of stigma. The research finds that even with ubiquitous HIV/AIDS education and prevention programmes throughout Botswana, Tswana engage in various kinds of risk taking behaviours as means through which impressions and identities as full persons of value may be managed successfully (*Afr J Reprod Health 2011; 15[1]: 95-100).*

Résumé

Stérilité et stigmatisation à une époque du VIH/SIDA : Narrations de l'évaluation des risques chez les hommes et les femmes au Botswana. Cette communication étudie l'expérience et les interprétations de la stérilité et la fécondité au nord du Botswana. Elle souligne spécifiquement le rôle de la stigmatisation et le traitement de l'impression chez les hommes et les femmes de Tswana à travers leurs narrations et discours concernant la procréation et la personne à une époque du VIH/SIDA. La communication démontre que dans un pays qui a un taux de séropositivité le plus élevé du monde, les pratiques sexuelles dangereuses sont mises en balance avec les normes culturelles, ce qui suggère que pour être une personne complète et un adulte productif, veut dire un homme ou une femme capable de procréer. A travers des recherches qualitatives longitudinales, les narrations et les histoires de la vie de plusieurs individus montrent l'évidence ethnographique sur le pouvoir de la stigmatisation. La recherche a découvert que même avec les programmes et l'éducation ubiquistes du VIH/SIDA à travers Botswana, Tswana s'engage dans plusieurs types des comportements dangereux comme des moyens à travers lesquels l'on peut traiter avec succès les impressions et les identités comme des personnes complètes qui ont de la valeur (*Afr J Reprod Health 2011; 15[1]: 95-100).*

Keywords: Botswana; HIV/AIDS; Infertility; Sterility; Stigma

Introduction

Infertility, or the inability to conceive after a year of regular and unprotected sexual intercourse, affects both men and women worldwide. Anywhere from 8-12% of people in their reproductive years experience infertility on average in cross cultural contexts and data from African contexts are a bit more difficult to accurately estimate, but health seeking behaviours related to infertility and sterility are reported to be about one third of all medical visits according to the World Health Organization and others.[1] How infertility and sterility are imagined and negotiated in particular cultural contexts is the subject of this paper and has been relatively undiscussed in the majority of infertility and sterility literature. In Botswana, there is some evidence reported that fears of infertility are voiced during clinical visits but still little actual data on how Tswana themselves perceive or understand or even negotiate and manipulate those concerns and their status.[2]

In Botswana, the unfortunate backdrop to all health concerns in the past two decades has been the advent and rise of the HIV/AIDS epidemic across the country.[3] At present the incidence rate is approximately 17.9% for the nation with some variation across urban and rural divides. The overall incidence is greater for women and youth aged 15-29 and despite greater emphasis on HIV/AIDS education and promotion in schools and in popular media, incidence and prevalence rates remain high across all ages.[4] The overall life expectancy however has risen in the past few years, in part due to the rapid dissemination of ARVs (antiretrovirals) across the country. While ARVs have increased longevity and overall quality of life, there is some ethnographic evidence to suggest that Tswana individuals report that many people feel "cured" of HIV/AIDS and as a result return or participate in unsafe sexual behaviours. As this paper illustrates, many of those risky behaviours are

driven out of a need to fulfill cultural norms and gendered expectations about personhood, reproduction and identity.

Many have argued that little research or emphasis is placed upon the study of infertility in sub-Saharan Africa[5]. A general stereotype persists that high African fertility rates make the study of infertility and sterility relatively less significant, both statistically and socially, and as a result little emphasis on infertility studies exists in demographic, health and ethnographic literature. While some literature exists that can address beliefs about the causes of infertility and sterility, little ethnographic data exists to demonstrate the lived experience of those conditions.[67] As is increasingly the case in Botswana, the role that social stigma plays in the negotiation of infertile or sterile status is key to understanding the kinds of risk taking behaviours that place individuals and families at greater risk for contracting HIV/AIDS and the interpretation of stigmatized or disabled identity in health care contexts.[8]

The purpose of this study was to gather an in-depth understanding of the perceptions of infertility and sterility among Tswana living in the northern part of Botswana, an area with fewer health clinics and access to fertility and reproductive health care. The study examines the experiences and narratives of infertile men and women as well as individual perceptions of those who struggle with impaired fecundity. The study also seeks to situate these narratives and explanations in the context of high HIV/AIDS infection and sought to uncover reasons why individuals might engage in risky sexual behaviours despite high levels of knowledge about the epidemic. The paper concludes with the suggestion that through studying the ethnographic narratives about infertility and sterility fears, the stigma and associated sexual risk taking behaviours can be better understood in this context. Studying infertility can illuminate how important childbearing is to construction of personhood and can have valuable insight for those grappling with HIV/AIDS policies and programme design.

Methods

Data for this paper were gathered over the course of several research periods in and around Maun, Botswana, a town in the northwest district of Ngamiland. Maun and the surrounding villages (with a population total estimated at approximately 30,000) is the hub of the tourism industry as it sits between the Okavango Delta and the Kalahari Desert. It is significant that this long term research has been conducted in Maun as it remains a relatively undiscussed part of the country in terms of literature and research on HIV/AIDS and ethnographic research that uncovers lived experience and social understandings of infertility. Research in this region of the country has tended to focus on the wildlife and the environment and the majority of research with respect to health and HIV/AIDS is conducted in Gaborone and cities more populous and arguably more accessible areas in the south. Most Tswana however identify as having a home village (natal) as well as a place of current residence and while these are often one and the same in the northern region, it is important to explore over the long term, just how similar or different attitudes and behaviours throughout the country may be. This research has been a longitudinal and much needed attempt to fill that gap in knowledge about rural/urban attitudes toward fertility in Botswana over a decade during which education and HIV/AIDS prevention programs have been on the rise.

The data were gathered during several long term study periods, from 1996-98, again in the months of June and July of 2003-4 and in 2008 and from 2009-2010. The strength of this ethnographic research has been the long term nature of the study and repeated visits to the fieldsite involved. This kind of ethnographic research provides longitudinal understanding of the cultural beliefs and behaviours that surround fertility desires among the Tswana. Observation and connections with individuals in the community of Maun have made thorough and more holistic research possible. Such qualitative research methods were used because of their appropriateness in obtaining in-depth understandings of infertility experiences across the life-course and shifts in narratives about beliefs and stigma associated with the HIV/AIDS epidemic over the last decade in Botswana. The research was therefore much more purposive than simple random sampling, individuals who have been familiar with the author over the years were able to recruit other Tswana in this rural area who were asked if they wanted to discuss fertility issues and concerns, cultural beliefs about fertility and HIV/AIDS awareness in their community.

For this paper, findings are drawn from the narratives of men (N = 20) and women (N = 31) who have been interviewed over research periods in the last decade and more. The narratives and data in this paper are drawn specifically from the most recent data collected, a subset of the longitudinal data and inclusive of those who are married, unmarried, fertile and those who identify themselves as having struggled with fertility problems. In addition to men and women in the participant group, three men who identified themselves as traditional healers (*ngaka ya Setswana*) and two female midwives were interviewed and asked over the course of the past several years about their experiences with patients and healing with respect to infertility in the context of HIV. Five medical personnel (two physicians and three nurses) employed at the local hospital and clinics were interviewed on several occasions. For the purposes of this particular paper the narratives and experiences of those fifty-one individuals who have in some way grappled personally with the condition or fears of infertility/sterility and/or who explicitly discussed this topic in multiple interview occasions, and who agreed to participate on more than one occasion over the past ten years during the HIV/AIDS epidemic

are included in the findings and discussion below. Not all of the fifty one therefore are considered infertile, but they have all been interviewed on numerous occasions over this time period and have specifically grappled with this topic in those interviews.

Data collection was a process of recording open-ended interviews that lasted for several hours, anywhere from 1- 4 hours, with often lengthier and more detailed interviews at the second or third interview period. Individuals were re-interviewed on at least two subsequent occasions. In order to code, systematically organize and compare the consistency of all of the unstructured and qualitative data gathered over this longitudinal period, ATLAS.ti software was used throughout the entire research process. Socio-demographic information collected in the questionnaire included the respondent's age, home-village, current residence (to note any rural/urban significance), years of education, languages spoken, occupation, lifetime marital history, sexual and birth history and knowledge about HIV/AIDS. The interviews were all recorded and transcribed verbatim. Verbal translation to English was assisted by a Setswana-English native speaker not involved in the study and the author entered all of the data to ATLAS.ti verbatim. The quotations included in this paper are used to highlight the themes that were identified in the data; the stigma fears and subsequent cultural patterns of behaviour associated with infertility even in the context of high HIV/AIDS awareness.

Results

The study findings suggest that for both men and women in Botswana, knowledge of HIV/AIDS in general is high and negotiating the stigma of HIV/AIDS is important. Most importantly and as noted elsewhere[910] a key to understanding and interpreting the findings from this particular narrative study, is the negotiation of the potential stigma of infertility and sterility. Fears of sterility overshadow fears of HIV/AIDS to the extent that the majority of individuals interviewed reported that they would engage in risky sexual behaviours and practices despite their high levels of education and knowledge of the epidemic. Certainly there are possible material and pleasurable aspects to seeking risky sexual encounters, but for the purposes of this particular study, and in every recorded narrative, Tswana (both fertile and infertile) *always* stated that having children in order to get married, stay married and to be seen as a successful person in Botswana was necessary above all else. Many were aware of infertility and potential causes as well as responses or possible treatments for infertility and sterility and while men and women varied some in their responses, the findings show that certain similar themes and intersections have emerged in the narratives and interviews.

Awareness of Infertility

A barren person or animal in Botswana is described as a *moopa*, *meopa* or *moopana*. Descriptions of such people include; they are unable to bear fruit, are desiccated or dried up, as useless, sterile and even as having transgressed some boundaries of normal Tswana behavior, as mentally and physically ill and disabled. Repeatedly narratives in response to questions about infertility or sterility status were grounded in fears of such status and an overt awareness and fear of being labeled a *moopa*. Awareness of negative stigma associated with infertility was consistent in every single interview or narrative collected over the years, at no point has an individual described infertility or fears of sterility in the case of men, as something that is either easily remedied or desirable. Indeed, mediating and negotiating identity and sexual stigma associated with infertility/sterility is a driving force behind many decisions that young adults make in Botswana. As these data show, for both married and unmarried Tswana individuals, the cultural importance and desire to bear children is paramount. These data include narratives from both those with children and those who admit to struggling with sterility concerns, some of whom had one biological child but were unable to have any more. This category of narrative is particularly interesting because it often correlates with those who had a child prior to marriage and have been unable to conceive in their current partnership (for either men or women) and often highlights how there are several cultural factors which contribute to potentially risky sexual behaviour in an era of HIV/AIDS awareness.

Knowledge about infertility and possible causes, fell into several categories: biomedical, supernatural or witchcraft explanations and individual behavioural factors (Table 1). Contraceptive use and medical interventions (such as abortion which remains greatly stigmatized, illegal and yet account for many follow up visits in hospitals) were described as direct contributors to thwarted fertility. Use of contraceptive pills and condoms are described as making one sick, as "*contaminating the blood, seeping into the blood and making the blood weak*". This description was true for women who were "eating the pills" as well as for the men who used a lubricated condom where the lubricant was thought to have affected the sperm strength. God's will and other supernatural explanations for the lack of children were evident as were explanations of jealousies and witchcraft performed by others in the community who were antagonizing the affected individual.

Awareness of HIV/AIDS

Knowledge about HIV/AIDS in Botswana in general is very high. In ethnographic data as well as statistical data from the Central Statistics Office it is clear that Botswana has had an extremely proactive and effective public campaign for awareness similar to other programs

and education campaigns in the African continent. Indeed, this is in part the cause of confusion on the part of many policy makers who observe the high levels of education, awareness and programming throughout the country and cannot make sense of the concurrent high levels of HIV incidence and prevalence rates and risk taking behaviours reported in ethnographic data. Again, it is precisely the qualitative data which can help to shed important light on this paradox. Narratives suggest several categories of knowledge about HIV/AIDS, these categories are similar to those cited above with respect to knowledge of infertility: biomedical, supernatural or witchcraft explanations and individual behavioural factors (Table 1).

Individual responses and explanations as to the causes of HIV/AIDS included male and female behavior (sexual and in general) in the past as well as exposure to HIV infected persons. Again, the role of witchcraft and the role of God and supernatural motivations were given as explanations for contracting HIV/AIDS, at times an explanation of bad fortune was given, as one young man stated, "*you just never know when you might get this [disease] it seems like just bad luck, some people can play all the time with lots of partners and never contract it, and others they fall sick right away, the moment they stray, it is hard to know, you just guess sometimes and take a chance*". As men and women cope with identities as infertile or sterile persons, it is always against a backdrop of the HIV/AIDS epidemic. What is particularly interesting then is where the explanations for both conditions intersect and how the negotiations involved with mediating infertile status contribute to the rise of HIV and how HIV/AIDS related stigma and the resultant discriminatory attitudes creates an environment and practices that continue to fuel the epidemic.

Male responses to managing sterility/infertility

For many men, the idea of infertility, or more commonly from a male perspective, the idea of sterility of not being able to reproduce or essentially produce enough viable sperm was a direct threat to their psychological sense of self and most importantly, their understanding and explanation of masculinity.

"Its like saying you are not a whole man, you are empty if your blood, your white blood [sperm or 'madi a masweu' in SeTswana] is not strong, if it will not produce a child and mix well with a woman's blood, then you will feel like you are still a small boy, that is what your relatives, even your friends will start calling you." [college-educated, urban 28 year old man, unmarried, father of one child]

Even for older men, the idea that being a reproductive person is inherently linked to an idea of masculinity was clear.

"These are not things we talk about, in the past you would never have someone like you [younger female researcher, non-MoTswana] asking about these things, everyone just knew too that no one wants to be seen as the man who is left behind, we call them like that, a lehetwa, like the calabash who is left to rot on the shelf, if nobody uses him [for sex and having chilren] then he is empty like that calabash, he has nothing inside and becomes dried up."[56 year old man, living in rural village, widower and father of five children, the first two of whom are from a relationship prior to his marriage]

The idea that fertility was literally and figuratively contained within men and women is clear. For many men, in discussing the above concept and description of a *lehetwa* was also the SeTswana proverb and expression

Table 1: Summary of causes of infertility and HIV/AIDS in Botswana

Infertility	HIV/AIDS
Contraception/Family planning	Contraceptives ('worms' in condoms seeping into men and women)
Drugs/alcohol	Female blood attacking male blood – disagreement
Weak sperm count	Women 'biting men' (witchcraft) – blood bites men and makes them weak
STDs and toilet diseases	Playing too much (too many sexual partners)
Hot or cold womb, slippery womb "unable to catch and hold a baby"	Sexual intercourse before marriage, "opening a woman"
Hot or cold blood	Women's blood being blocked, attacking male blood
Mopokwane (breaking sexual taboos)	Having sex with someone one shouldn't (during mourning, postbirth confinement)
Spoiled girls (sexual intercourse before marriage) or concubines (*nyatsi*)	Stress and anxiety
No menstruation or late menstruation, "blocked bloods"	Blood pressure
Men not having enough sexual release, "blocked male bloods"	Bewitched woman, jealous partners and relatives
Problem with blood agreement	
The woman herself is the problem bewitched, jealously	

**All causes were mentioned at least five times by those in the study and appeared as causal factors in long term re-interviews of individuals.*

one hears in many discussions of sexual behavior and masculinity, "a man is like a calabash because he can be passed around to many women" and even "a man is like an animal, a bull who cannot be contained in a single kraal."[11]

Male responses about potential infertility or potential sterility also included responses to women and their blood and bodies. For example, as one resident of a rural village stated,

> *"Sometimes a woman's blood is too hot – you can feel it when you are with her [have sex with her] and it will cause problems for your own blood. Maybe she has been bitten by [a virus] or something is affecting her like some kind of sexual problem, or she broke a taboo, but as a man, and to stay a man, you want to be sure your blood gets cooled down, so maybe you sleep with someone else, you end up sharing your blankets with someone who is a better match and who can balance out that other woman".* [33 year old man, married and father of four children]

It is interesting and important to note that for many men, their sexual behavioural responses are characterized as something they feel they have little control over – they must maintain healthy blood in order to be seen as virile men and that in turn requires multiple sexual partners – both for the establishment and maintenance of potency as well as for restoration of any imbalances caused by women partners.

Female responses to managing infertility/sterility

There is a Tswana proverb which states, "you know a cow is a good cow if it has a calf". Many women talked about the value of children in similar terms, arguing that children are financially important, "who will take care of you when you are an old woman if you do not have any children?" was a common refrain from both urban and rural dwelling women in this study. More importantly however, women talked about problems associated with their identities if they were without children, beyond just a simple economic explanation. As one married, 36 year old college-educated woman with two children and a job at the university described,

> *"it is important not to be spoiled, to not spoil yourself and that includes playing too much before you get married or with too many people who are married themselves (being a concubine or 'nyatsi' in Setswana), even too much education such as myself, people will believe that you have drained yourself somehow, you have put too much energy into your head, and your womb might be dry and if you cannot produce a child, there is a real fear about you, I could produce all the publications and lectures possible, but without a child, people will look right through me, they will not see me".*

Women it seems are in a real double bind too, whereas men are openly encouraged to be "passed around" and experience many sexual partners, women are told to bear children, but to do so in ways that do not "damage" their social status. If they break sexual taboos[12] or behave in ways contrary to what the community views as socially healthy (staying on one's own without family members for example) women are subject to intense scrutiny about any subsequent fertility status. For women who seem to be "passed around" and have many concurrent partners or engage in intergenerational sexual partnerships they might worry that they are being chastised by god or ancestors for their behaviours if they fail to "fall pregnant". The refrain "*petso ya Modimo*" (God is chastising/critiquing me) is heard often as women grapple with a need to be reproductive persons while simultaneously being seen as good and socially respectable persons.

For women too the importance of fertility is captured by the use of particular names and words in SeTswana. A woman becomes known as the "mother-of-her child's name" once she has children and her own birth name is lost. In many ways the "solution" offered by outsiders to the stigma of infertility and as a way to address the risk of many sexual partners in the search for fertility, adoption, does not make sense as an acceptable solution in Tswana society. Many women and even some men in this study and through their narratives suggested that "doing adoption" was not viable because "the child and others will always know the true mother and want to leave to go back to that one". As one 48 year old married woman and mother of three biological children said to me when we were discussing the viability of adoption in cases of suspected sterility,

> *"it is not possible for that child to stay in that household, it is in its nature, it will want to go back to the lolwapa [household or compound] where it is from, it is in the body, the body will know and will know that this woman or this house is not healthy, there will be fear from the child that the infertility might jump into it and it will not stay.*"

For many Tswana, the idea that infertility and the subsequent stigma it connotes is so great that even the possibility of remedying the situation of a childless household through adoption does not appear as a feasible strategy or solution.

For Tswana men and women therefore the importance of fertility is intricately and inextricably intertwined with the notion of themselves as full and competent persons in society. Yet in the search for the realization of that identity, individuals find themselves caught in the complicated web of HIV/AIDS education and prevention strategies. It asks the Tswana person to consider whether the ubiquitous messages about HIV/AIDS are to be prioritized (a task difficult when everyone openly talks about HIV and treatment seems to exist in the form of ARVs or anti-retrovirals which have greatly enhanced quality of life in the country) over deeply held beliefs about what constitutes a good, moral person in society, the bearing of children and maintenance of unspoiled and healthy identity, the rejection of barrenness and non-sexual behavior.

Negotiating Risk and Stigma

Tswana individuals actively weigh the perceived risks of HIV positive status with a negative fecundity status. Up to this point, most HIV/AIDS policy programmes and education strategies have focused on prevention of the former but to the detriment of the latter, deeply ingrained cultural beliefs. HIV status and knowledge about one's HIV status can therefore stand in the way of fulfilling fertility desires and cultural needs in the definition of personhood. For instance, as one young woman stated,

"*No one wants to be rejected you know? So if you go to the clinic and they tell you that you are HIV positive, then you are the one who has to disclose that, that is what they tell you, but if you disclose that information, who is going to have a relationship with you after that? There is a lot of talk about being faithful but who really knows if your [male] partner is doing that so it comes down to a trust game where you are trying to guess who is going to be faithful and who is not*". [21 year old student, unmarried and mother one child]

As others described, the process of negotiating and considering the risks of contracting HIV or another STI against the possibility of infertility and non-personhood is constant and the stakes are very high. As several young people discussed,

"*if you go out a lot but do not [have sex] with men, people will think there is something wrong with you, that you are sick or something is wrong, something in your body is going to prevent you having sex and you will not end up with a child in the future, that is a serious problem.*" [22 year old woman, unmarried, no children]

"*I would say that I am an educated, empowered woman and I still think it's important [to have children]. If I want to have a husband or even a partner some day, I will have a child. So that means that I have to not think sometimes when I am out with friends, I have to forget what I know about HIV and just go with what God has put before me…if he puts a person who is sick, maybe I will not know that, but at least I can have a child and someone to take care of me*." [25 year old woman, unmarried, one child]

"*most women, they have an appetite for money and status, they want to have a baby with an older man, or even their boyfriends so that they get nice things, computers, cell phones, whatever it is. Our stipends at University do not cover these things, so you see girls who have many sugar daddies and it's just accepted. They used to say that it was only men who didn't want to eat a sweet with the wrapper still on [use a condom] but nowadays it's the girls too, they say the plastic hurts them, it will hurt their chances in the future and for the future. It was fine for a while to be cool and abstain, but gradually you see, the old ways come back and you want to make sure that you are not left behind. What if I finish school and am the same as I started, just a child myself?*" [23 year old man, unmarried, no children]

And one older man, married for twenty years with four children and living in a rural area suggested,

"*it is still the case that despite the HIV/AIDS, people will want to have children more than anything else, it is a problem. In the past maybe they were asked to leave school if they fell pregnant too early in schooling, but now, they are risking their lives, but it is a problem because you don't see them with good role models. Adults these days, even teachers, they set examples of how important it is to have a child and then you can follow the AIDS advice*".

And poignantly, one health care worker noted,

"*the risk of HIV/AIDS is very high. But it is invisible, you don't always know if you have it, or your partner has it, even if you come for testing, it might show up later. But for most people, it is more of a risk if a child does not show up later, you cannot hide that, children are visible. So what would you do? What do you expect people to do? If you cannot control your HIV, maybe at least you can try to control having a child, at least that's what I see*" [35 year old woman, married with three children, one born prior to her marital partner]

And a young man who argued that it was in many ways far riskier to tamper with fate and essentially abdicate responsibility for either condition,

"*your life is written down before you are born, so why bother to try to change it. You can cover up parts that you don't want others to see, but you yourself cannot change anything in that path. So you just enjoy it, go with it and see what is meant to happen, there is no use trying to change the path or will of God, either way, if you get AIDS or you get a child, that is not really up to you*". [26 year old unmarried man, father of two children with his current girlfriend]

From marking adulthood to demonstrating health and stigma free personhood, fertility and childbearing are important for both men and women in Botswana today. Given the backdrop however of HIV/AIDS, these narratives of negotiating infertility are particularly important. Understanding the driving force and role that fertility plays for both men and women is the key to understanding still present HIV/AIDS rates and the risks that individuals take despite high levels of knowledge and education and empowerment.

Discussion

Two things stand out in the findings in particular. One is the obvious parallels and intersecting explanations for infertility/sterility and HIV/AIDS. Specifically, the same explanations of contraceptive use, blood

disagreement and the breaking of sexual taboos appear in each table as explanations for both conditions. Second, the explanations for each condition are highly gendered. For the most part, women bear the brunt of responsibility for the cause and spread of the disease, whether it is infertility and sterility or HIV/AIDS. These findings are significant. Particularly so for policy makers and others who have tended to treat the HIV/AIDS epidemic without a careful notion of gendered causes (at least in the Tswana layperson mindset) and grounded in a biomedical model which does not make such distinctions. In addition, and for the purposes of this paper – the qualitative narrative data demonstrates that when making decisions about sexual behavior – the risk associated with infertility seems to overshadow the risks of possibly contracting HIV or another STI. Ultimately becoming a full and fruitful person outweighs the seemingly ubiquitous and ironically, less stigmatized identity as someone with HIV. As one woman working in the nursing ward of a urban hospital put it,

> "*many people have HIV, there are many treatments people have for HIV, there are educational programs for HIV, but none of that exists for infertility, so that one [infertility] seems worse and you have to hide that problem more…there is no UN program for infertility treatment here, nobody cares like they do about AIDS so for people, that is much worse*". [38 year old woman, mother of one child and who described herself as someone who struggled with many miscarriages and subsequent infertility]

Infertility is indiscriminate. It affects individuals world-wide and physiologically can affect both men and women. In different cultural contexts however, certain individuals may have greater chances of contracting infertility and becoming sterile than others. In Botswana, both physiologically and socially, women are seen at greater risk for contracting infertility and subsequently end up at greater risk for HIV/AIDS and other STIs. As this study demonstrates, this can lead to a cyclical pattern of risk and impression management where narratives of infertility and stigma are inextricably linked with those of HIV/AIDS.

It is not enough to suggest that support groups or adoption services should be highlighted, improved and made readily available to men and women in Botswana. Rather, it is important to emphasize the value of long term qualitative research in areas that have been vastly understudied in the country as these kinds of data can provide more useful explanations as to why individuals participate in certain kinds of risk taking sexual behaviors. What drives the fears behind infertility and sterility stigma for example are important cultural mores that have far more to do with Tswana understandings of personhood and identity than simply the need for adopting children into a household. Discussing the stigma of infertility too is not something that can be easily addressed or "corrected" without careful consideration of the factors which drive the need for reproduction in order to be seen as a full, complete, and productive person in Tswana society.

The implications of the study for efficacious HIV/AIDS policy and programme design can be especially powerful. Prevention programs which have focused upon the need for condoms and other prophylaxes have overlooked the very fundamental pronatalist concepts of personhood implicit in Tswana culture. Gender and power differences have been markedly overlooked as well and only recently has more attention been paid to the role of women in determining childbearing and the weight of their narratives about the necessity to have children. The majority of BaTswana are aware of HIV/AIDS and effective means of prevention at some level. However, what is clear through these long term qualitative sets of data is that individuals make choices based upon deeply held beliefs about personhood and gender identity prior to the long term risk management of HIV/AIDS possibilities. HIV/AIDS is unfortunately ubiquitous in Botswana, but if many are at risk, the more immediate risk and needs for impression and identity management come in the form of the ability to bear children and therefore prove a healthy, productive and thus reproductive self.

This paper demonstrates that Tswana are engaged in constant negotiation of their fertility status. This is not to suggest that individuals are unaware or uncaring of their HIV/AIDS status, rather, that the two must be carefully negotiated and weighed against one another. The stigma associated with HIV/AIDS and the resultant discriminatory attitudes and fears of repercussions creates an environment in Botswana that continues to fuel the epidemic. Through use of ethnographic data, explanations of stigma and the processes through which individuals negotiate risk and their identities as (re)productive persons are made clearer.

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