

The Out-of-School Youth and HIV/AIDS in Rural Botswana

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This research was undertaken to establish the extent of knowledge of out of school rural youth on HIV/AIDS; and their attitudes towards HIV/AIDS and condom use. A total of 37 out of school youths, made up of 22 males and 15 females were surveyed between December 1998 and January 1999 in Kang village in Botswana. It was observed that, on average, youth were knowledgeable about HIV/AIDS issues; that the ones with adequate knowledge were those who attained junior and senior secondary education; and that in general, the youth have positive attitudes towards HIV/AIDS, people with HIV/AIDS, and condom use. The radio was identified as the most effective, and the poster as the least effective measure for the dissemination of information on HIV/AIDS in rural areas. The findings indicate that those with inadequate knowledge require reinforcement from programmes, especially in the area of prevention against HIV/AIDS; and that social workers, nurses, doctors and the kgotla could play larger roles in the dissemination of information on HIV/AIDS to youths in rural areas.

Introduction

HIV/AIDS is a challenge for all societies in the world. It is a global problem which cannot be treated in isolation, especially, in a context where mobility and interaction between communities are becoming more complicated. UNAIDS (1998) estimates that 7000 young people, aged 10-24, get infected with the HIV virus everyday, that is, five young people every minute get infected. Also, it is estimated that 1.7 million young people in Africa get infected with the HIV virus every year. Worldwide, it seems that most of the new cases are in Africa, and 60% of the newly infected or HIV positive are young people of 15-24 years (UNAIDS,

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1994). In most Sub-Saharan African countries, the rural areas are as well affected, and in certain cases, the HIV/AIDS situation is more critical (UNAIDS, 1998).

The first case of HIV/AIDS in Botswana was officially reported in 1985. Since then, the number of people with HIV/AIDS has continued to increase at an alarming rate. AIDS Action Trust (1994) points out that the number of people infected with the HIV virus rose from 60 000 in 1992 to over 125 000 by 1994. According to Lt. Mompoti Merafhe, Botswana's Minister of Foreign Affairs, 207 000 people had been infected with the HIV virus in Botswana, by June 1997. This represents an increase of 82,000 infections between 1992 and 1997. The rapid HIV virus spread does not only affect urban population in Botswana. The rural areas have not been spared in the alarming spread of HIV/AIDS infection (Government of Botswana, 1997).

UNAIDS (1998) indicates that youth friendly information that keeps the realities of young people in mind, is often lacking. It continues to argue that morality, culture and religion are taken as reasons to deny young people their right to education about the health risks of sexual and other behaviours, and to important tools and services for protection (UNAIDS, 1998). On the aspect of knowledge about HIV/AIDS, Alao et al (1995), argue that adolescents in secondary schools appear to be relatively knowledgeable about issues related to HIV/AIDS. However, they also note that those in junior schools (form 1 and 2) are not as knowledgeable as the ones in senior secondary schools (forms 3-5). In a study of teacher training colleges, Feringa (1988), found that students were very knowledgeable about HIV/AIDS. Again, Lesetedi (1988), in her survey of knowledge of women between 15-49 years old on AIDS, reveals that women are not well informed about AIDS and its spread.

A sentinel surveillance survey found increase in HIV seroprevalence among pregnant women in Botswana between 1992 and 1995, indicating a rapid spread of the epidemic in rural areas. For example, the study shows that in the Serowe/Palapye region, HIV seropositivity increased from 19.9% to 26.7% in 1993 to 29.9% of 262 subjects in 1995. In Kasane/Chobe region, the figures increased from 18.3% to 37.9%, while in Gantsi the prevalence increased from 9.5% to 18.9%. It is noted that in the survey, youth accounted for 75% of the HIV positive pregnant women, with their male counterparts accounting for 68% of the reported cases in the 15-29 age group

(Government of Botswana, 1997).

From studies such as by Malacca (1995), Alao et al (1995) and Lesetedi (1988), it is evident that the information on HIV/AIDS caters, in most cases, for school-going youth and tend to neglects the out-of-school youth, especially those in the rural areas. In trying to provide answers to questions raised by young people about HIV/AIDS, there is need to understand their knowledge about, and attitudes towards HIV/AIDS so as to establish the impact of programmes aimed at behavioural and attitudinal change towards HIV/AIDS.

The paper, therefore, examines the knowledge and attitude of out-of-school rural youth toward HIV/AIDS. It is taken from a larger study on the subject. The need to undertake such an examination comes from the contention that "in most cases, it is not possible to reach the out-of-school youth in HIV/AIDS educational programmes and campaigns" (UNAIDS, 1988:5). Specifically, the paper discusses the type, and extent of knowledge of out-of-school rural youth towards HIV/AIDS and condom use, given the prominence of condoms in the fight against HIV/AIDS.

Study Site

The study was conducted at Kang village, situated in Kgalagadi North, about 150 kilometres west of Jwaneng township. The 1991 population census puts the population of Kang at 2 734, including those people living in the localities near Kang (Government of Botswana, 1991a). Much of this population is considered quite mobile, because of the constant search for employment in urban areas. 45% of the transmission of Hiv/AIDS between urban and rural Botswana has been attributed to the existence of these mobility patterns, as well as sexual behaviour patterns which include multiple partners (Government of Botswana, 1993).

The village has quite a number of social services which include a primary school (standard 1-7), one junior (form 1-3), and one senior secondary (form 4-5) schools. Available data show that the population aged between 5 years and 20 years was 1967, of which 905 were males and 1062 were females. Out of this population, only 608 were at school or school going, 692 had left school for one reasons or the other, and 667 has never attended school at the time the census was conducted (Government of Botswana, 1991a).

Methodology

The method employed was sample survey and the study was descriptive in nature. The subjects in this study were out of school rural youth aged between 12 and 29 years. The study population comprised of 1349 out of school youth (Government of Botswana, 1991a). It was hoped, that about 50 out-of-school youths would be identified and interviewed. However, the total number of subjects reached for the study was 37 respondents. The survey was conducted in December 1998 and January 1999.

Sample selection was done through snowball sampling. This method was chosen because no sampling frame was available, and one could not be constructed. This made it difficult to know exactly where each out-of-school youth was located. The snowball method relies solely on a respondent's knowledge of where other respondents could be found (Babbie, 1992). This might have contributed to the limited number of respondents identified, and the large number of male respondents compared to females. Data collection was done through self-administered questionnaire and administered schedule based on the literacy levels of the respondents. Self-administered questionnaire was used with the out-of-school youth who have been to school and were literate, while the administered schedule was conducted with those who have never been to school and those who were semi-literate.

Characteristics of the sample (Table 1)

The data indicate that 2(5.4%) of the out-of-school youth fell in the age range of 12-15; 19(51.2%) were between the ages of 16 and 20; 9(24.3%) were between the ages of 21 and 25; and 7(18.9%) fell in the age range of 25-29. This indicates that the majority of the respondents, that is, 20(81%) were young people with ages ranging from 12-25 years. The sample consisted of 22 males and 15 females. This might be due to the fact that snowball sampling depends highly on the knowledge of respondent about other respondents. As such, more males introduced other respondents (from the same sex). However, the Central Statistics Office shows that in 1991, 385 females in Kang had left school and 361 had never attended school compared to 07 males who left school and 296 males who have never been to school (Government of Botswana, 1991a). Another plausible explanation of the predominance of male respondents may be exactly the fact that traditionally, female roles usually kept them at home or in the field for chores while males

have more freedom of movement.

Table 1: Characteristics of the Sample

Age	No.	%
12-15	2	5.4
16-20	19	51.4
21-25	9	24.3
25-29	7	18.9
Total	37	100
Sex	No.	%
Male	22	59.5
Female	15	40.5
Total	37	100
Educational level	No.	%
No education	2	5.4
Standard 7	4	10.8
Form 2	16	43.2
Form 5	14	37.8
Other	1	2.7
Total	37	100
Occupation	No.	%
Unemployed-seeking employment	16	43.2
Employment-unskilled	6	16.2
Working at home/agriculture	6	16.2
Employed-skilled	5	13.5
Employed-temporary	4	10.8
Total	37	100
Marital Status	No.	%
Single	37	100
Married	-	-
Divorced	-	-
Cohabitation	-	-
Total	37	100

According to the data, all 37 (100%) respondents were single even though the majority, 35(94.6), fall among the marriageable ages (14+ years for females, and 16+ for males in Botswana). However, the important point to note, is that, the respondents have not passed the marriageable age and therefore, could still be preparing for marriage. These are people who have settled down with respect to the acquisition of skills and holding satisfactory jobs, and hence may not be ready for marriage as yet.

The data show that 35(94.6%) of the respondents have attended school. Thus, only 2(5.4%) of the respondents have no formal education at all. 4(10.8%) reached standard 7; 16(43.2%) attained junior secondary education; and 14(37.8%) attained senior secondary education (form 3-5). The remaining 1(2.7%) had a Trade B qualification in carpentry. The data indicate that a majority, 35(94.6%), of the respondents have attained both primary and secondary level of education which are the two levels of education which most Batswana have attained (Government of Botswana, 1991b). Despite the small sample, the data show that a higher number of out-of-school males have attended secondary education (form 3-5) compared to females who represented only 4(10.8%). This supports the findings by Chilisa (1997) that there are more males in senior secondary school enrollment than females. This suggests that more females drop out of school after junior secondary school than males.

The data show that the occupation of the youth surveyed varied. The majority of the respondents, 16(43.2%), were unemployed and seeking work with males representing 9(56.3%) of the unemployed population and females accounting for 7(43.8%). 6(16.2%) of the respondents were involved in traditional agriculture or working at home, and another 6(16.2%) were employed in the informal sector as traders, vendors and dressmakers. There were 5(13.5%) employed and skills respondents who were males. One was a soldier in the army, 2 were carpenters and 2 were customary court police officers. The remaining 4(10.8%) respondents were employed temporary and held jobs such as teaching, drought relief officers and assistant agricultural officers.

The data support the notion that unemployment is one of the major problems facing young people in Botswana. The problem is manifested extensively in rural areas. This is so mainly because of lack of appropriate and adequate skills among school leavers, and non availability of employment

opportunities in rural areas, thus making it more difficult for them to acquire jobs. The 1991 unemployment statistics show that the youth in Botswana are the hardest hit by lack of employment. Young people aged between 15-34 years account for 66.3% of the total population looking for jobs (Government of Botswana, 1991a).

Information about HIV/AIDS (Table 2)

All 37 (100%) respondents indicated that they have heard about HIV/AIDS. 25 respondents heard about HIV/AIDS from the radio, 8 respondents cited the hospital/clinic; 5 indicated social workers; 4 listed doctors and health workers; while 2 got information from newspapers. Only 1 respondent indicated that the public poster was the source of information about HIV/AIDS. The data suggest that the AIDS awareness educational programmes for rural areas should put more effort on transmitting information about HIV/AIDS through the radio since it appears to be the most effective mode of communication in this rural area. In addition, social workers, clinics and hospitals should make information about HIV/AIDS accessible to youth as much as possible. The least sources of information were public posters and the newspapers, indicating that the audio or broadcasted information reach the out-of-school youth more than the written information on HIV/AIDS.

Table 2: Sources of Information about HIV/AIDS

Sources of Information	Number*
Radio	25
Hospital/clinic	8
Social worker	5
Doctor/health worker	4
Newspaper	2
Public Poster	1

* Multiple responses allowed.

Preferred Source of HIV/AIDS Information (Table 3)

When asked where people should get information about HIV/AIDS, the majority of respondents, 22, identified clinics and hospital as the major sources of information, followed by social workers and radio with 12 respondents each. 6 of the respondents said people should get information from schools, while 4(10.8%) designated the family and newspapers as places where people should get information. Thus, the health clinic or hospital has a lot of potential of spreading information about HIV/AIDS in rural areas. A possible implication of the study is that, perhaps the respondents believe that the clinic and hospital can provide more accurate information on the issue. Although the church, kgotla, peer educators and family as sources of HIV/AIDS information are ranked low, all these have the potential to reach a large number of youths with adequate and timely information if properly utilized.

Table 3: Where people should get information about HIV/AIDS

Where should people get information about AIDS?	Number*
Clinic/hospital	2
Radio	12
Social Workers	12
School	6
Newspaper	4
Family	4
Kgotla meetings	3
Peer educator	2
Church	2

* Multiple responses allowed.

Knowledge about HIV/AIDS (Table 4)

Respondents were assessed on adequacy of their knowledge on issue related to HIV/AIDS. Only 6(16.2%) revealed inadequate knowledge about HIV/AIDS. With reference to gender, 2(9.1%) of the 22 males in the study displayed inadequate knowledge compared to 4(26.7%) of the female

respondents. Knowledge about HIV/AIDS issues was high among those with junior and secondary levels of education. Over one quarter, 11(29.7%), of the respondents believed that mosquitoes could transmit the HIV/AIDS virus. 34(91.9%) knew that HIV/AIDS virus could not be spread by "sharing food or cups" or by "using public toilets". All 37(100%) knew that a person could not get HIV/AIDS from shaking hands, touching and kissing on the cheek of someone who has the HIV/AIDS virus.

The majority of respondents, 30(81.1%), correctly identified the statement that "birth control pills can protect women against HIV/AIDS" as false. 36(97.3%) did not believe that "men don't have to do anything to protect themselves from getting HIV/AIDS" and identified the statement as false. 34(91.9%) respondents identified the statement that "a person can get HIV/AIDS by sharing unclean needles with drug user" and "a person can get HIV/AIDS through unclean blades and knives used by traditional healers" as true. All 37(100%) respondents felt that using a condom during sexual intercourse reduces the risk of getting the HIV/AIDS virus. Out of 37(100%) respondents, only 2(5.4%) did not know that HIV/AIDS does not have a cure, thus identified the statement "there is no cure for HIV/AIDS" as a false statement.

The data illustrate that knowledge of respondents on HIV/AIDS issues differ in accordance with their educational status. Respondents with no education and those who have attained primary school education (standard 1-7) reveal inadequate knowledge about HIV/AIDS issues. The respondent in these categories believe that mosquitoes can transmit the HIV/AIDS virus; that one can get the virus from using public toilets; that HIV/AIDS is more common among older people; that one can get the virus from bad luck; and that birth control pills can prevent HIV/AIDS. The data seem to support the contention by the AIDS/STD Unit (1994) that education is strongly correlated with knowledge across locations, and that those with low education were more likely to be involved in the most high risk behaviour because of inadequate knowledge. However, a majority of the respondents revealed adequate knowledge about HIV/AIDS issues suggesting that AIDS campaigns have reached a widespread audience in the area. But, while the level of general awareness of HIV/AIDS has been raised through public information and education, efforts are still required to dispel myths, misconceptions and misunderstandings about HIV/AIDS.

Table 4: Responses to Statement about HIV/AIDS

Statement	No. of True Responses	%	No. of False Responses	%
Condoms reduce the risks getting HIV/AIDS	36	97.3	1	2.7
HIV/AIDS is transmitted sexually.	36	97.3	1	2.7
There is no cure for AIDS.	34	91.9	3	8.1
HIV/AIDS can be transmitted using unsterilised equipment.	34	91.9	3	8.1
Mothers can pass on HIV/AIDS virus to their babies.	29	78.4	9	24.3
Mosquitoes can transmit HIV/AIDS.	11	29.7	26	70.3
HIV/AIDS is common in older people.	10	27	27	73
Getting HIV/AIDS is bad luck.	9	24.3	28	75.7
HIV/AIDS can be contracted through the use of public toilets.	8	21.6	29	78.4
Birth control pill prevent AIDS.	7	18.9	81.1	81.1

Condom Use (Table 5)

The data indicate that 36(97.3%) of the respondents disagree with the statement that condoms are not good for Batswana men; 34(91.9%) disagree

that condoms should only be used with casual partners; 32(86.5%) disagree that condoms have pores that transmit HIV/AIDS; 26(70.3%) disagree that condoms should only be used with sex workers; 27(73%) disagree that condoms make sex less enjoyable; 19(51.4%) disagree with the statement that condoms are 100% safe. Also 31(83.8%) respondents disagree that condoms should only be used with spouses or regular partners; 35(94.6%) disagree that people who carry condoms are loose; and 2(5.4%), disagree that it is a man's responsibility to always carry condoms.

From this data, it is evident that the youth have positive attitudes towards condom use and a good understanding of related issues. For example, 36(97.3%) respondents agree that women should also carry condoms and 35(94.6%) also agree that condoms are easy to use. However, it may be disturbing to note that 10(27%) respondents agree that condoms make sex less enjoyable and 6(16.2%) believe that a true Motswana man never uses a condom. Even though these figures appear not to be high, they indicate that a lot still needs to be done in the area of youth sexual beliefs, sexuality and related behaviour (Ahmed et al, 1997).

Attitudes towards condom use, HIV/AIDS and people with HIV/AIDS**Table 5: Responses to Issues Related to Condom Use**

Statement	S/A No.	%	A. No.	%	D. No.	%	S/D No.	%
Condoms are not good for Batswana men.	1	5.4	-	-	13	35	23	62.2
There is no need to use a condom with casual partners.	3	8.1	-	-	14	37.8	20	54.1
Condoms are easy to use.	18	48.6	17	45.9	2	5.4	-	-
Condoms have small pores that transmit HIV/AIDS.	4	10.8	1	2.7	17	45.9	15	40.5
Condoms should only be used with sex-workers.	6	16.2	5	13.5	16	43.2	10	27
Condoms make sex less enjoyable.	3	8.1	7	18.9	12	32.4	15	40.5
Condoms are not 100% safe.	7	18.9	11	29.7	16	43.2	3	8.1
A true Motswana man never uses a condom.	3	8.1	3	8.1	16	43.2	15	40.5
I would prefer condoms being distributed by a person of the same sex as myself.	27	73	10	27	-	-	-	-
People who carry condoms are loose.	2	5.4	-	-	18	48.6	16	43.2
Women should also carry condoms.	22	59.5	14	37.8	-	-	1	2.7
Condoms should only be used with spouses or regular partners.	5	13.5	7	18.9	17	45.9	9	24.3
It is always a man's responsibility to carry a condom.	3	8.1	6	17	18	48.6	10	27

S/A = Strongly Agree. A = Agree. D = Disagree. S/D = Strongly Disagree.

The data support the findings of the AIDS/STD Unit (1994), that the attitude of young people towards condoms is much more positive than the previous years. This is a sign that youths are changing their sexual behaviour. When asked why they thought condoms should be used, some of the respondents said that "unsafe sex should be seen as risky, and condom use appears to be the best method to prevent the spread of HIV/AIDS". It must be noted that the promotion of condom use needs to be accompanied by availability of information on how to use it, and skills on how to be comfortable around condoms. This is because positive attitude does not ensure change in sexual behaviour.

Respondents were asked whether they often used condoms with their partners. 19(51.4%) said they use condoms almost always, 5(13.5%) use them about half the time and 3(8.1%) hardly ever used them. The remaining 10(27%) said they did not use condoms because they did not have partners. Of the total number of respondents, 23(62%) indicated that they usually get the condoms from the clinic or hospital, 5(13.5%) cited the chemist while 7(18.9%) get them from general dealers. 6(16.2%) indicated that they get condoms from other places including friends. Of those using condoms, 24(88.9%) reported that they used condoms because they wanted to protect themselves from HIV/AIDS and other sexually transmitted diseases. 1(3.7%) used condoms to prevent pregnancy and 2(7.4%) used condoms because they did not trust their partners.

From the data, there are no respondents who indicated that they always used condoms. The data, therefore suggest that the "condom use culture" to contain the spread of HIV/AIDS is not yet adopted by the youth in rural areas where the use of condoms is highly associated with promiscuity and other immoral behaviours (Ahmed et al, 1988). Because of the reason that condom is associated with social and moral ills, its use is determined by other factors such as its collection without embarrassment. The data are in line with Quarraishar et al (1992) who point out that condoms are rarely used due to unfamiliarity, issues of love and trust and difficulties in negotiating their use with partners. These play a very significant role in the final decision to use them or not. Since HIV/AIDS is a chronic public health problem, the challenge facing health education, social work and other social practices is one of establishing risk reduction practitioners as a routine part of everyday life, rather than as an emergency measure. The HIV/AIDS campaigns must seek to normalise condom use and encourage its adoption as an everyday

occurrence rather than as a practice intended to meet the specific problem of HIV/AIDS.

Attitudes towards HIV/AIDS

When asked if they would feel ashamed if they had HIV/AIDS virus, 23(62.2%) of the respondents said they would be ashamed and 14(37.8%) said they would not be. 36(97.3%) felt that HIV/AIDS is a serious health problem in Botswana. 36(97.3%) indicated that most people of their age should worry about HIV/AIDS (agreement indicates a positive response). 34(91.9%) of the respondents disagreed with the statement that "HIV/AIDS can be contracted from a curse or witchcraft". The data show that in general, out-of-school youths in Kang have a positive attitude towards HIV/AIDS. In addition, it is evident that some of the myths and misconceptions about HIV/AIDS have been removed. However, the responses still reveal some of the stigma attached to HIV/AIDS infection.

This might be because HIV/AIDS is still taken as a result of deviant behaviour. The fact that the respondents knew that HIV/AIDS cannot be contracted from a curse or witchcraft is important for education programmes, especially, those that seek to change sexual behaviour, manage HIV/AIDS and treat those infected.

The data also reveal somewhat mixed attitudes towards people with HIV/AIDS. 35(94.6%) said that they could have someone with HIV/AIDS as a friend. 37(100%) respondents also indicated that they could visit people with HIV/AIDS virus. When asked if people with HIV/AIDS should not be isolated from society, all 37(100%) said they should not. However, 22 (59.4%) of the respondents believe that anyone who catches HIV/AIDS has himself or herself to blame, showing negative attitude. These results appear, in part, to support Lesetedi (1988) who argues that the attitude of Botswana toward people with HIV/AIDS is discriminatory. In addition, this may indicate that the endeavour to change people's attitudes is not producing the desired results in rural areas. This reveals that the attitude of "blaming the victim" is still prominent and indicates that substantial education efforts are still needed to improve societal attitudes towards people with HIV/AIDS. It must be noted that the AIDS/STD Unit (1994), in a study on monitoring trends in youth sexual behaviours, found that attitudes towards people with HIV/AIDS have started to improve across all locations in Botswana. It

reveals that between one quarter and one third of the respondents affirm that HIV/AIDS patients need to be accepted by the community.

It is evident from the data that respondents felt that people with HIV/AIDS should be accepted and given respect. However, with the youth, this does not appear to be the same as taking the HIV/AIDS patients' side or acting as their advocates, but rather recognising their needs and interests. 8(21.6%) respondents said that they should be given financial assistance and nursing care. Only 4(10.8%) of the respondents said that they should be isolated and 1(2.7%) said they should be killed. The results show that there is need to continue to encourage positive attitude towards individuals with HIV/AIDS. Respondents were also asked who should give support to people with HIV/AIDS virus. 12(32.4%) respondents felt that relatives or family members should provide assistance to people with the HIV/AIDS virus; 11(29.4%) indicated the community as a whole; 6(16.2%) identified social workers; 4(10.8%) identified doctors/nurses; and 4(10.8%) pointed out the government. This may indicate a shift from dependence on government provision of social services to family and community responsibility in this area. Furthermore, this might be an indication of the fact that messages about home and community based care are being reinforced or gaining root.

Majority of the respondents, 33(89.1%), felt that HIV/AIDS is highly serious compared to other diseases in Botswana. When asked what they thought their chances were of getting HIV/AIDS, 20(54.1%) indicated that they did not know, and 6(16.2%) said that the chances were fair. 5(13.5%) indicated that their chances were low, and 3(8.1%) noted that the chances were high. Another 3(8.1%) said that there were no chances that they would be infected with the HIV/AIDS virus.

The respondents were asked if they had sexual intercourse with their partners. Majority of the respondents, 28(75.7%), have had sexual intercourse and only 8(21.6%) had never had sexual intercourse with their partners. Of those ever having sex, 19(67.9%) reported currently having regular partners and 9(32.1%) did not have regular partners. In general, relationships tended to be short term. For example, 8(21.6%) of the respondents indicated that their relationships normally last between one and six months; 1(2.7%) respondent has relationships lasting from 7-12 months; and 11(29.7%) have relationships lasting for more than 12 months

The data illustrate that there is high prevalence of sexual activity and permissiveness among the youth. There is also a high incidence of changing sexual partners over a period of less than 12 months among the respondents. This may be attributed to the imbalance in the sex ratio between males and females in Botswana, and that males and females engage in multiple and infinite relations for gratifying their sexual desires and in search for a long lasting union (Ahmed et al, 1988). Also, engagement in sexual relationship in Botswana at any level of relationship is still regarded as a "true" sign of love (AIDS/STD Unit, 1994). As such, the spread of the pandemic through heterosexual contact remains a major mode for HIV/AIDS transmission in the country. The data also support the statement by Ahmed et al (1988:23) that educational programmes that emphasize the need "to have sex with one partner" to avoid catching HIV/AIDS have not been effective.

Conclusion

Knowledge and attitudes studies are based on the belief that correct knowledge, when combined with desirable attitudes will motivate individual's positive behaviour. However, the complex nature of human sexuality is such that people may not necessarily act on knowledge that they have, even when the result of their action may prove detrimental to their health status. In the wake of the HIV/AIDS epidemic, young people, the most sexually active group, are increasingly becoming infected by HIV/AIDS. There appears to be a causal relationship between education and the level of knowledge about HIV/AIDS among the out-of-school youth. For instance, those who either did not acquire formal school education or dropped out too early tend to be ignorant of the risks involved in sexual activity and are more receptive to early sexual contact and associated problems.

There has been an increase in the awareness of, and knowledge about AIDS and methods of prevention among the youth. However, there is no major indication of a significant reduction in such risk behaviour as having multiple sexual partners: unwillingness to use condoms, and changing sexual partners within a short period of time. Many young people believe that they need only use condoms with casual partner, and that the use of condoms under such circumstances meant that they could safely engage in even more multiple-partner sexual encounters without any negative consequences.

The findings of this study fail to support the findings of similar studies which indicate that the youth do not have information and thus have inadequate knowledge on HIV/AIDS issues. The respondents in this study revealed adequate knowledge, in general, about HIV/AIDS issues despite the fact that they live in a rural area. This suggests that HIV/AIDS and AIDS prevention messages have reached young people. However, more HIV/AIDS education is needed at primary school level and in non-formal institutions to bridge the gap in knowledge that exists between different educational levels.

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