



Republic of Botswana
Ministry Of Education

Knowledge, Attitudes And Practices Of Teachers And Students On HIV and AIDS

Baseline Study Report



**Botswana Institute For Development Policy Analysis
August 2003**

BIDPA

25556/2



Knowledge, attitudes and practices of
Botswana Institute for Development Policy
Book 614.5993 BID



KNOWLEDGE, ATTITUDES AND PRACTICES OF TEACHERS AND STUDENTS ON HIV/AIDS

BASELINE STUDY REPORT

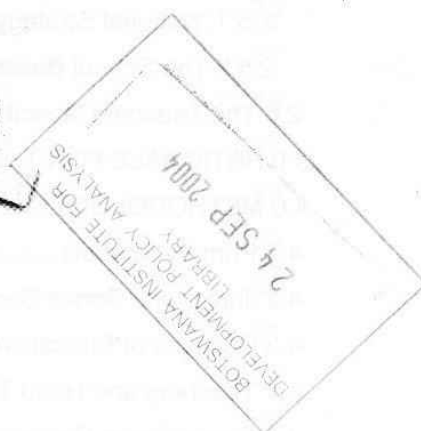


MINISTRY OF EDUCATION



BOTSWANA INSTITUTE FOR DEVELOPMENT POLICY ANALYSIS

AUGUST 2003



Teacher Capacity Building Project Baseline Study 2003

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EXECUTIVE SUMMARY

The increasing prevalence of HIV/AIDS in Botswana has prompted the Government to come up with various strategies, among them the Teacher Capacity Building Project (TCBP). The major objectives of TCBP are a reduction in spread of HIV infection in the country by targeting teachers as disseminators of information on HIV/AIDS in order to effect change in behaviour especially through interactive learning. The government perceives prevention through education as the best way to combat HIV/AIDS infection. Schools offer an appropriate setting for this education, but the capacity of regular classroom teachers to provide health and HIV/AIDS education with knowledge and comfort may be limited by a lack of HIV/AIDS related training and by attitudes and values. Hence it was found imperative to launch a baseline study which will unveil the prevailing misconceptions, attitudes and stigma about HIV/AIDS among teachers and students.

The monitoring and evaluation is perceived to be an important aspect of TCBP. This is to facilitate evidence based planning for interactive learning in schools. To provide a continuous evaluation of TCBP a baseline was commissioned. This baseline provides basic information needed to strategize and prioritize programs under TCBP during its implementation. The present report details the observations of the baseline survey among the students and teachers. Two surveys were administered to ascertain teacher and students' knowledge, attitudes, and values about HIV/AIDS. The survey assessed HIV/AIDS knowledge of 1731 teachers from 105 selected schools and tertiary institutions and almost 6000 students.

BACKGROUND TO THE STUDY

HIV/AIDS has become a serious health and economic problem in Botswana. The prevalence rate has more than tripled since 1992, from about 10 percent in the 1980s to about 35.8 in 2001. In 2002 UNAIDS estimated the number of children living with HIV/AIDS at about 28, 000 in Botswana. With an infection rate of about 35 percent of the sexually active adult population, the pandemic affects every sector of Botswana. The Economy is likely to suffer shortages in the labour force and high medical expenses. Botswana will experience an increase in the number of orphans, and associated with this could emerge antisocial behaviour towards orphans.

HIV/AIDS is expected to have a negative impact on Botswana's demography. UNDP (2001) estimates infant mortality rate to rise from 45 deaths per thousand to 1,000 by the year 2010. A major change in the population structure is also expected by the year 2010, by which time UNDP anticipates a '40 to 50' percent fewer proportion of Botswana adults aged between 35 to 45 than would be without the HIV/AIDS pandemic.

UNDP identifies several factors related to the spread of HIV/AIDS, namely: culture, gender inequality, poverty, stigma, denial, population mobility and urbanisation.

The Gross Enrolment Ratio (GER) and the Net Enrolment Ratio (NER) indicate that access to primary and secondary education has increased dramatically between 1993 and 1999. The NER of 99.5 in 1999 indicates that at that time only 0.5 percent of children between the ages 7-13 were not enrolled. The GER of ages 7-13 in 1999 stood at 117.8 percent showing that children outside this age group were enrolled. Transition rates in 1999 from primary to secondary also had improved with about 96 percent of primary school leaving age getting access to secondary education. Primary school drop-out decreased from 6,942 to 6,390 between 1998 and 1999. There was a decrease in the drop-out due to ill health from 3.6 percent to 2.8 percent of all reasons for dropping out of school at primary level. Drop-out as a result of death increased marginally in the same period from 1.6 percent to 1.8 percent. Pregnancy also decreased from 3.1 percent to 2.2 percent. Desertion constituted the bulk of drop-out reasons at primary, at 86.9 percent. However, at secondary schools pregnancy made the bulk of the drop-out reasons at 42 percent, followed by desertion at about 40 percent in 1999. Death and illness constituted a tiny proportion of drop-out at 2.2 percent and 3.6 percent respectively.

These results indicate that unprotected sex does take place at primary and is rife at secondary schools. Drop-out between 1998 and 1999 due to ill health and death at secondary schools has increased marginally from 3.1 percent to 3.6 percent and 1.4 percent to 2.2 percent respectively. The marginal increase in death and ill health could be explained by the fact that sex at secondary school appears to be intra-generational (see Section 6.4) and therefore the chances of the older folks who may be predisposed to HIV/AIDS coming into sexual contact with younger uninfected persons are limited.

However, government is deeply concerned about the spread of HIV/AIDS and remains committed to fighting the epidemic. To this end the government has adopted a multi-sectoral approach that brings on board the private sector, NGOs as key stakeholders. Among the many strategies, government has adopted the school based approach and the Teacher Capacity Building Project to combat the spread of HIV/AIDS among students. In September 1998 the government introduced the HIV/AIDS policy that among other developments made the integration of HIV/AIDS into education compulsory at all levels. The TCB project seeks to enhance the capacity of teachers to deliver the HIV/AIDS prevention message in schools in an effective manner that would achieve the objectives of an AIDS free generation by 2016.

RESULTS AND FINDINGS

Students

Most students are aware of HIV/AIDS, but the awareness varies according to the education level of the students from 73% awareness in primary schools to 96% in senior secondary and tertiary schools. Awareness about HIV/AIDS seems to correspond with the usage of condoms. The level of usage varies according to education level and improves at higher levels of education compared to lower levels. More 90% of students at all levels of education indicated that they could get condoms easily if they wanted them. However a significant number indicated that they couldn't. For most sexually active, hospitals, family planning clinics and government health centres are the main top three places to get condoms. However, even though more than half of students from primary and junior secondary schools reported to be receiving very good treatment from health facilities in the country, the percentage falls below half in senior secondary and tertiary schools.

But there are many challenges: almost 27% of primary, 13% of Junior Secondary Schools; 4% of Senior Secondary School, and 4% of Tertiary Schools students are not yet aware of AIDS. In addition, among sexually active students it's only a few in lower levels of education that always and sometimes resists having sex without a condom. This is further compounded by the fact that the majority of students have never tested for HIV/AIDS, especially among those in lower education levels. This highlights that a lot of students are exposed to the

dangers of being infected with HIV or falling pregnant at lower levels of education. The need for more aggressive information on safe sex, especially targeting lower levels of education beckons.

The challenges may be complicated by reported incidence of transactional sexual activity among a few sexually active students, who reported having sex for money (but since this question was more direct it could explain why only a few students responded to it); the early age at which many students initiate sexual activity (6-10years); and the number of students who report having multiple sexual partners especially in junior and senior secondary schools. Nonetheless, data indicate that some key opportunities to influence these behaviours still exist. As much as a significant number of students indicated having had sex before, especially at senior secondary schools and tertiary institutions, the majority of primary and junior secondary school students indicated that they have not yet had sexual intercourse. This suggests that aggressive preventative programmes have the chance to encourage these students to delay the initiation of sexual intercourse as well as to provide them with the education and resources to make safe sexual choices if they do become sexually active.

An analysis of the teaching methods used in schools to disseminate HIV/AIDS prevention message indicate that the most common approach is for the teacher to ask the class some questions, practice writing, whole class discussions and working in groups. At primary level the most popular method is question and answer approach (49%), practice writing 48%), class discussion (36%), students finding out things themselves (30%), working in small groups (25%), and being allowed to pursue different also scored the least at 25 percent. A similar pattern prevails at all levels of the education strata, with tertiary scoring very little on small groups (16%) and the pursuit of different things by students coming the least but one at 21.5 percent. Interactive learning such as working in small groups and allowing students the initiative to find things out themselves are not methods commonly applied by teachers.

Teachers

The socio-demographic profile of teachers interviewed show that there was almost an equal proportion of those staying in the urban and rural and peri-urban areas. The majority of the teachers (55.7 percent) were married, and an overwhelming majority (90.9 percent) was

heterosexual. Homosexuals, lesbians and bisexuals accounted for only 2.5 percent, 0.5 percent and 6.1 percent respectively.

Teachers portrayed a fairly good understanding of HIV/AIDS, as well as reflecting a generally positive attitude towards HIV/AIDS. The study established a positive and supportive attitude towards HIV/AIDS among teachers with a better understanding of HIV/AIDS. Further to that female teachers fared better in this respect than their male colleagues. However, there were some of the teachers who harboured some misconceptions about the spread of HIV/AIDS. For instance, about 11 percent indicated that HIV/AIDS could be transmitted through kissing and 6 percent said through mosquito bites, 2.7 percent said through sharing utensils, and sharing toilet 4.6 percent. Analysis of the data shows that male teachers seemingly have more misconceptions about the transmission of HIV/AIDS. For example, about 99 percent of males indicated that shaking hands, kissing (88 percent), sharing utensils (97 percent) against the females' 1 percent, 22 percent and 3 percent respectively.

Furthermore, correlation coefficients show that some perceptions about HIV/AIDS vary according to gender. For instance, there is no significant correlation between marital status and prevention methods of HIV for female teachers, whereas for male teachers there is a negative and significant correlation between marital status and antiretroviral medication. This implies that unmarried people believe that antiretroviral drugs can prevent HIV infection more than those who are married or divorced. Also there is a positive and significant coefficient of correlation in the level at which a teacher teaches with sticking to one partner. Results indicate that if one moves from being a primary school teacher to higher levels of education, the perception of sticking to one partner to prevent HIV/AIDS gets stronger.

The responses given by teachers indicate that they are knowledgeable about the symptoms of AIDS. However, the older the teacher (both males and females) the more pessimistic one becomes about the well being of somebody who is HIV positive. However, marital status seemed to positively and significantly correlate with the perception that "a person with AIDS looks well and healthy." Nevertheless, there is a high level of awareness about the way an HIV positive person looks and feels among teachers of all levels.

The sexual behaviour of teachers is critical to the baseline study as teachers are responsible for imparting knowledge on HIV/AIDS to students. The assumption is that a teacher with risky sexual behaviour is less likely to alert students about the risks involved in certain behaviour with regard to HIV/AIDS. The majority of teachers indicated that they have had sex before, with only 4 percent indicating that they have never had sex. The average age at first sex indicates that many had first sex in their adulthood, at 21 years for males and 18 years for females. The prevalence of promiscuity among the teachers seems too high, with about 72 percent indicating that they have had multiple partners in the last 12 months. Only 39.8 percent of the females who had sex with non-regular partners used condoms and 51.2 percent of the males also reported using the condom in their last sexual encounter. The prevalence of risky behaviour also corresponds with age, the younger the teacher the more casual relationships they are likely to get involved in. However, it is encouraging that about 72 percent of the teachers who reported having had sex before consistently used condoms in the last 12 months. A larger proportion, 76 percent, indicated that they were aware that sexual abstinence plays a critical role in preventing the transmission of HIV/AIDS. About 4.3 percent of the teachers indicated that they have had sex with someone they knew was HIV positive, and 17 percent of these said they did not use a condom. This shows that in spite of being aware of the risks of HIV/AIDS, some teachers still behave in a risky manner.

Intergenerational sex seems not very wide spread in primary and secondary schools as compared to tertiary institutions. About 70 percent indicated that they have never had sex with somebody 10 years their junior. About 21 percent indicated that they have had sex with somebody ten years younger than themselves, and 9 percent said they did have sex with somebody more than ten years younger than themselves. Multiple partner sex behaviour seems common in tertiary schools where the average per teacher is 9 partners, 6 for primary school teachers, one for Community Junior Secondary Schools (CJSS), and 3 partners for Senior Secondary Schools (SSS).

Headmasters Perceptions

Headmasters are the custodians of the educational system. They have over the years accumulated valuable information and knowledge about the educational system and the challenges the schools are faced with. This includes also, information about the impact of HIV/AIDS on the school system, Interactive Learning techniques and the Teacher Capacity Building Project in general (TCBP). The quality of the education system and its capacity to use Interactive Learning methods to address HIV/AIDS issues is correlated to the use of both qualified and unqualified teachers. However, a significant number of schools still use temporary and/or untrained teachers. Mostly the number of the unqualified teachers in each school ranged from between 1-5. Only 5 percent of the primary schools and 30 percent of the CJSSs had between 6-10 untrained teachers. The tertiary category reported having between 16-20 unqualified teachers. It is doubtful if the Interactive Learning methods can be successfully implemented given the high proportions of unqualified teachers.

It is apparent that most teachers had difficulty answering questions relating to the capacity building teams largely because the concept is still new and may not have been introduced to them yet. Indications are that the Visitor Exchange Programmes are also not be widely implemented. Exchange programmes broaden the teachers exposure to new ideas and concepts that they may later use to improve their delivery of the HIV/AIDS prevention message. Forty eight percent of the Headmasters indicated that they have Interactive Learning trained teachers among their staff, with 35 percent having received no training yet. About 47.6 percent of the Headmasters indicated that their schools actually practice Interactive Learning approaches with 36.5 percent claiming that their teachers are proficient. However, data indicates that a substantial number of Headmasters may not be familiar with what Interactive Learning is all about. For instance about 47 percent claimed to have IL trained teachers, while to the contrary a higher number (48.6%) than those who indicated they have trained teachers said they have teachers who actually practice Interactive Learning. Many of the Headmasters also responded to the questions with the "Not applicable" answer when asked about Interactive Learning, Visitor Exchange Programme and the Capacity Building Teams, which shows they do not know what all these are about. More effort will be needed to familiarize schools with these methods or approaches to combating the spread of HIV/AIDS.

It is encouraging that about 66% of the schools indicated that they practice Peer Education. And this exposes teachers to new ideas and enhances their openness. Peer Education enables the active participation of students in disseminating information about the prevention of the spread of HIV/AIDS. The efforts garnered through Peer Education in the prevention of the spread of HIV/AIDS complements the TCBP initiatives.

Teacher absenteeism from work seems high. About 27 percent of the schools reporting indicated that they have experienced teacher absenteeism amounting to 20 man-days in a year with about 20.3 percent indicating that they have lost about 15 man-days due to absenteeism. Among the schools reporting, the primary schools were the most affected by teacher deaths, having lost about 32 teachers in the past 12 months from selected schools. Among the selected schools, senior secondary schools lost four teachers through death and junior secondary schools indicated that they lost two teachers only.

As for students the baseline data indicates that drop-out rates are highest among females, especially at CJSS. However, pregnancy did not constitute the most common reason for drop-out. Only 6.4 percent of girls at primary dropped-out due to pregnancy, 27 percent at CJSS, and 12.1 percent at SSS. Social problems accounted for 68.8 percent of the reasons for female drop-out at both primary and CJSS, while SSS incurred 57.6 percent. No females were reported to have dropped out of school at SSS due to illness, 3.9 percent for CJSS, and 15.8 for primary schools. Illness accounted for 9 percent, 5.5 percent and 6.6 percent of drop out reasons for boys at primary, CJS and SSS respectively. Social problem reasons may be good indication of the HIV/AIDS problems at home, with school children taking up the role of care givers to the infected, some leaving school to become bread winners.

School clubs which could become powerful instruments for HIV/AIDS prevention message dissemination are not well entrenched in schools. Only 27 percent of the schools interviewed indicated that they have HIV/AIDS clubs about 22.8 percent said they have Scripture Union Clubs, 5.4 percent have 4B clubs and only 4 have PACT. This also indicates the absence of Peer Counselling among students in the school system. The promotion of these clubs is crucial with regard to establishing HIV/AIDS awareness campaigns in schools. Funding has been singled out as the most impeding factor for the clubs to prosper. This could be one

dimension that the TCB project to address to revitalize clubs that could carry out the campaign.

CONCLUSIONS AND RECOMMENDATIONS

Significant differences between students and teachers emerge with regard to awareness levels regarding HIV/AIDS and sexual behaviour. Gender, the level of education, as well as geographic location play a significant role in the differences. Female students and teachers and rural residents were more disadvantaged compared to their urban counterparts. Both students and teachers seemed to be generally aware of the condom as a common preventive method of HIV/AIDS infection. However, some grey areas with regard to understanding HIV/AIDS became apparent in the study. These need to be addressed as a priority, and that new teachers should undergo some specialised training related to HIV/AIDS.

Many students complained about the largeness of the standard condom size, claiming it is too big for them to use it effectively. This indicates the interest of young people in taking precautions to protect themselves and their sexual partners. This is one of the essential elements to behaviour change that the school-based interventions must address.

Peer pressure was blamed for early sexual encounters among boys while cash inducements in exchange for sexual favours were indicated among girls. Most students interviewed were of the opinion that condoms should be distributed in schools and also outside for the out-of-school youth to benefit as well.

Although most students seemed to have a better understanding of HIV/AIDS transmission most had negative attitudes towards those who are infected. This could be as a result of lack of understanding, socialisation and other factors like cultural influences. Varied expertise, such occupational health expertise, may be necessary for the creation of positive attitudes among students towards the infected.

Cash and other inducements as well as the promise to marry lure young women and girls into risky sexual relationships. Addressing sexual abuse in schools is a key human rights issue and a tool in the fight against HIV infection and AIDS. Myths and stereotypes exist among the

students and these need to be addressed. Engaging HIV infected persons to speak in TCB projects could dispel myths and stereotypes by adding a human dimension to the whole process.

The incorporation of teacher education programmes into the project could enhance the teachers understanding of policies and could potentially ameliorate any problems especially between the infected and uninfected teachers. Stigmatisation and discrimination inhibits both teachers and students to test for HIV/AIDS. to address these social service organisations need to be brought into the mainstream to sensitise communities, including students, about the needs of infected people.

More counselling and guidance is needed especially for students with infected parents. Students can hardly deal effectively with a parent's illness and death. These, however, do affect the child's morale at school with some ending up deserting or dropping out of school. Both parents and teachers have expressed concern that there is a need to address difficult issues related to HIV/AIDS in which children need support.

The TCB project should be able to improve awareness of the consequences of unsafe sexual behaviour and increase the understanding of measures needed to reduce the incidence of HIV/AIDS amongst identified high risk groups through surveys and progress reports. Furthermore the TCB project should increase the effectiveness and confidence of teachers in delivering the safe sex message at schools through both formal and informal mechanisms. Students felt that parents could play a major role in the prevention of the spread of HIV/AIDS. But many students felt that parents evade issues related to HIV/AIDS and safe sex practices. It is crucial for the TCB project to involve parents in the process especially through the Parents Teachers Association (PTA). Both teachers and parents have to acknowledge that students do engage in sex, whether it is right or wrong for them to do is another matter. The issue at hand is that students do indulge in sex and both teachers and parents have to find common strategies to assist students to do it in a safer way.

Listed below are the key specific recommendations.

1. Design participatory approaches and programmes for peer discussions and peer education amongst all students on HIV/AIDS issues and actions.

2. Integrate HIV/AIDS syllabus into the curriculum at all educational levels.
3. Improve the capacity of teachers to be able to effectively handle HIV/AIDS awareness programmes.
4. Enhance the participation of parents in HIV/AIDS education through the PTA.
5. Promote student/youth friendly clinics in public health institutions.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organisation
FBO	Faith Based Organisation
GoB	Government of Botswana
HIV	Human Immuno-deficiency Virus
MOE	Ministry of Education
NGO	Non-governmental Organisation
TCBP	Teacher Capacity Building Project
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
STD	Sexually Transmitted Disease
SSS	Senior Secondary School
CJSS	Community Junior Secondary School
TS	Tertiary Schools
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
PACT	Peer Approach to Counselling by Teens

ACKNOWLEDGEMENTS

This report was prepared by Ministry of Education under a consultancy with Botswana Institute for Development Policy Analysis (BIDPA). The study was a partnership between the United Nations Development Programme (UNDP), African Comprehensive HIV/AIDS Partnerships (ACHAP), National Aids Co-ordinating Agency (NACA) and Ministry of Education. The reference group consisted of officials from these organisations. The group assisted a great deal in not only funding the study but also in providing comments and suggestions throughout stages of study. Their contribution made this study a reality.

The goal of this baseline study is to determine levels of knowledge, attitudes and practices in relation to HIV/AIDS among students and teachers in selected schools in Botswana. The success of the data collection depended on their co-operation. All students, and most teachers, headmasters, principals and PTA members were co-operative. They patiently self-administered the questionnaire and actively participating in focus group discussions.

Several stakeholders contributed to the data collection process through provision of transport. To mention only a few, many thanks go to UNDP and NACA for providing vehicles for the entire duration of the field work. From the private sector, BOCCIM contributed towards field work by providing a vehicle for data collection at below market rate.

Many thanks go to the BIDPA team who worked tirelessly during the field work, the data processing, analysis and report writing. The research team comprised Dr N.H. Fidzani (Team Leader), Dr C.K. Kerapeletswe (Deputy Team Leader), Mr M. Phirinyane, Mr. K. L. Lisenda and Mr. L. Batsetswe. Several BIDPA staff members were involved in the project in many ways. These include Mr T. Kayawe and Mr J. Maiketso who assisted in the data collection and the drivers who worked extended hours and away from their duty station, the procurement officer who assisted in duplication of the questionnaire and binding of reports, and the executive secretary who assisted in setting up appointments for the research team with different schools and institutions.

1.0 INTRODUCTION

The Government of Botswana (GoB) is currently confronted with the challenge of responding to the growing HIV/AIDS (Human Immunodeficiency Virus/Acquired Immuno Deficiency Syndrome) epidemic. It is apparent that determinants of the epidemic and some of the factors that continue to fuel it lie outside the health sector. Presently the pandemic afflicts close to 40 million people worldwide, almost three quarters of whom are found in sub-Saharan Africa (Akoulouze et al., 2001). Behind these colossal figures lies the adverse social and economic impact of the epidemic on people, families, schools, and other key institutions necessary for development.

The GoB's response has been characterised by a prevention strategy supported by a multi-sectoral programme involving partnerships between government departments, civil society, NGOs (non-government organisations) as well as the private sector, faith-based organisations, the youth, traditional healers and traditional leaders. The education sector, like many other sectors, has not escaped the ravages of the HIV/AIDS epidemic. Indeed, available evidence indicates that the relationship between HIV/AIDS and education is a complex one, but the bottom line is that the epidemic is having a significant impact on education. On the other hand, given that there is neither cure nor vaccine for HIV, education is seen as and indeed it is proving to be a social vaccine that can roll back the epidemic as evidenced by experience of Brazil. Undoubtedly, education is the cornerstone of the contemporary prevention strategies most notably the Information-Education-Communication approach that has been widely adopted in the fight against HIV/AIDS. Because of the potential education has in transforming the spread of HIV/AIDS, the Ministry of Education has not sat passively but have actively acted to control the epidemic and its ravages in the education system. A variety of interventions have been designed and implemented. The Teacher Capacity Building Project (TCBP) is one of the strategies adopted by the Botswana government for an effective response to this challenge.

Based on the above objectives, the MoE launched a baseline study to obtain baseline information about knowledge, attitudes and practices in respect of HIV/AIDS. The stated terms of the study are reference are:

1. To undertake research to identify knowledge level. Related attitudes, behaviour and beliefs of school youth and teachers in relation to HIV/AIDS including gender issues, sex and sexuality amongst the ten percent institutions identified for close monitoring (representative of school community)
2. To investigate and report on the extent of interactive lessons on HIV/AIDS undertaken in schools to establish the current trends
3. To identify and report on the different strategies currently used by schools to address HIV/AIDS related issues
4. To produce a report outlining existing knowledge gaps, related attitudes, behaviour trends and beliefs (fears) of teachers and school youth.
5. Analyse both qualitative and quantitative data collected from the field
6. Compile the findings and consolidate views in a report form

The report below presents a summary of the main findings of the baseline study. It is divided into five main sections. The first section focuses on the background to the study which entails a general overview of HIV/AIDS in Botswana and its impact on the education sector. The second and third sections deal with the rationale for study and methodology. The fifth section addresses the data collection and analysis aspect of the study. The sixth section presents findings on respondents' knowledge, perceptions, attitudes and beliefs about their HIV/AIDS.

Following through on male–female relations, section three examines the incidence of and attitudes towards use of condoms, multiple partners, serial partners and sex behaviour in general. It also presents findings about attitudes towards those who are living with HIV/AIDS and the stigma of being HIV positive.

Given the mass and richness of information gathered during this baseline study, this summary report must be seen as a first step in highlighting some of the HIV/AIDS issues confronting students and teachers. To enhance our understanding of the multitude of factors that impact

on students and teachers in relation to HIV/AIDS, there is clearly a need to strengthen further research in this area, particularly focusing on factors that facilitate or hamper interactive learning that can bring about behavioural change.

2.0 Background to the study

2.1 General Overview of HIV/AIDS in Botswana

In many countries in southern Africa, up to one-tenth of the adult population (aged 15-49) is infected with HIV. In Botswana, a shocking 35.8% of sexually active adults are now infected with HIV (CCA, 2001). The first known HIV case in Botswana was diagnosed in 1985. The adult HIV prevalence rate in Botswana has more than tripled since 1992, when it was an estimated 10%. The youth are the most affected by HIV/AIDS. In the first quarter of 1996 the estimated number of infected youths accounted for 56% of the reported cases of HIV signs and symptoms (GoB, 1997). According to the 1995 Sentinel Surveillance Survey 79% of the HIV positive pregnant women were the youth (op cit). The National AIDS Coordinating Agency (NACA) 2001 HIV Sero-prevalence Sentinel Surveillance Survey indicates that infection prevalence among the age group 15 - 19 was increased from 16.4% in 1992 to 24.1% in 2001. In the same period, among the age group 20 - 24 years infection rate increased from 20.5% to 39.5%. Although the increase of HIV prevalence among these age groups was slower than all other age groups, the prevalence rate has nonetheless increased and remains a national concern. Also, about 28,000 children aged 0 - 15 years were estimated to be living with HIV (UNAIDS, 2002).

Botswana's high HIV prevalence rate is the highest in the southern African region. According to UNDP's Human Development Report 2001, 150 000 women aged 15 to 49 are HIV positive. Given a population of only 1.6 million, these figures indicate that few families remain unaffected by HIV/AIDS in Botswana. The HIV/AIDS pandemic affects every sector of Botswana. Politically HIV/AIDS threatens the survival of the state of Botswana given that almost 40% of the adult population is infected with it. Such a large fraction of the population with a life-threatening disease can cause instability. Economically the pandemic will create a serious reduction in the labour force and a heightened increase in health expenditure. On humanitarian grounds, one of the tragic results of the HIV/AIDS pandemic in Botswana is the increase in orphans, who are at risk of abuse and violence, and at a greater risk of antisocial behaviour. HIV/AIDS also poses a threat to the achievement of the goals of education for all and thus to development in general as discussed above. This means that HIV/AIDS can no longer be dealt with simply as a disease under the auspices of a health ministry.

2.2 HIV/AIDS Prevalence in Botswana

According to UNAIDS/WHO Epidemiological Fact Sheet 2002 Update, there is an estimated 330, 000 adults and children living with HIV. The number of those who died of AIDS during 2001 stood at 26,000. orphaned children, that is those who have lost their mother, father or both parents, who were alive and under the age of 15 in 2001 were estimated at around 69, 000 (UNAIDS, 2002).

The spread of HIV/AIDS is expected to negatively impact upon Botswana's demography. The United Nations Development Programme (UNDP) estimates Botswana's infant mortality to increase dramatically from 45 deaths per 1,000 births in 1991 to 148 deaths per 1,000 by the year 2010 (UNDP, 2001, P.43). UNDP further estimated life expectancy in Botswana to have dropped from 65 years in 1993 to 41.9 years in 2000 (op cit). However, the UNDP's life expectancy estimates were refuted by the Population and Housing Census Report 2001, which posted new estimates. According to the Central Statistics Office (2001), life expectancy for Botswana is estimated at about 68.2 years. However, UNDP estimates a dramatic change of the population structure by the year 2010. It is estimated that there will be about "40 to 50 per cent fewer Botswana adults aged 35 to 45 than would have the case without an HIV epidemic" (UNDP, 2001, p.45).

Tuberculosis (TB) has also reached epidemic proportions. The number of TB infections having fallen to an average of 10.9% per annually between 1980 and 1989 has now risen to 537 per 100,000 persons between 1990 and 1996 (op cit). It also accounts for about 36% of AIDS mortality, which is the single leading cause of death among AIDS sufferers in Botswana (UNDP, 2001). The spread of HIV in Botswana has been attributed to various factors including culture, gender inequality, poverty, migration, urbanization and stigma and denial (op cit). And these factors are discussed in the following section.

2.3 The Factors Influencing the Spread of HIV in Botswana

The UNDP Common Country Assessment (2001) has identified several factors that influence the spread of HIV/AIDS in Botswana and these include culture, gender inequality, poverty, population mobility, stigma and denial as well as urbanization. These factors are discussed below.

2.3.1 Culture

Some of the cultural factors blamed for the prevalence of HIV/AIDS in Botswana are the greater attachment to fertility, the societal acquiescence to males' practice of having multiple partners, and the practice of men having sex with younger women in exchange for small gifts and money (UNDP, 2001). The issue of men having sex with younger women is predominant among women from poor households. The problem also affects school children which amounts to intergenerational sex.

However, as for fertility it has been declining significantly over the past two decades in Botswana and this nullifies assertions that 'greater attachment to fertility' contributes to the rise in HIV/AIDS. The available demographic data indicates that Botswana no longer place any importance over fertility to the extent purported by UNDP. There has been a decline of the fertility rate in Botswana from 4.2 % in 1991 to 3.7 % in 2001. Both the average size of households and the annual rate of population growth have declined significantly (Table 2.1).

Table 2.1: Fertility Rate, Household size and Rate of population Growth

	1991	2000	2001
Fertility Rate	4.2%	3.8%	3.7%
Average size of Household	4.7		4.1
Annual Rate of Population Growth	3.5%	2.2%	2.1%

Source: CSO, 2001

2.3.2 Gender Inequality and Poverty

The majority of the ethnic groups in Botswana are patriarchal. Marital and inheritance customary laws still discriminate against women. For instance, in customary law men are allowed polygamous marriages and traditionally married men are known to have concubines with whom they often have children. According to customary inheritance laws only the youngest son inherits the homestead. Although this is discriminatory against women, the UNDP's assertion that it contributes to the spread of HIV/AIDS (UNDP, 2001, p.48) is being blown out of proportion. In any case, even if a woman inherits a house if she gets married she will still have to leave the house and stay with her husband in the husband's house. Also, unlike the UNDP's assertion, it is very rare for men to evict their sisters from the inherited homestead. Even if it may occur it would be exceptional rather than being the norm. However, the general impoverishment of women comes through the skewed distribution of inheritance assets such as cattle and boreholes in favour of men, leave women severely economically and socially disadvantaged. Cattle and access to grazing land are both an important economic asset and status symbol in Botswana society. Women without any economic power and lowly social status are more likely to be dominated and abused by their husbands and/or lovers.

About 50 % of the households in Botswana are female headed and poverty is severest among these (BIDPA, 1987). Women from disadvantaged households are likely to engage in risky sexual behaviour to try to earn a living (UNDP, 2001). Also, the girl-child from female headed households, which are most likely to be poor, are predisposed to being taken advantage of by men.

As rightfully noted by UNDP (2001) violence against women is on the increase. Rape, coercive sex and the defilement of girls are increasing. It is very unlikely that somebody could rape an individual they respect. So, this also reflects on the society's gender stereotypes.

2.2.3 Population Mobility, Urbanisation and Economic Boom

Traditionally Botswana have three homesteads, the village home, the fields/lands and the cattle post. To all these have been added (to a significant number of the population) a home in

the towns or cities. These places are visited quite often, mostly at every month end especially between the villages and towns. Visits to the cattle post and fields are also frequent especially to pay the workers their monthly wages. Consequently casual or short-term sexual liaisons are common (UNDP).

Traditional family networks have also broken down as a result of urbanization. Over 50 % of the population lives in urban settlements, which with their anonymous lifestyle offer greater opportunities for short term sexual relationships that involve high-risk behaviour (UNDP).

Botswana is located at the centre of the Southern Africa region, and her booming economy as well has attracted various nationalities from neighbouring countries which also have high incidences of HIV/AIDS. Also, Botswana provides a good corridor for the movement of goods in the region, with long distance truck drivers

Economic boom has led to infrastructural developments taking place across the country, which involves the movement of crews of men (mostly) to projects sites. Many leave their families and other long time sexual partners behind for prolonged periods, which tempt both partners away and at home to engage in short term sexual relationships. Poor women along projects sites also engage in risky sexual behaviour for some economic gain.

2.3.4 Stigma, Denial and Traditional Beliefs

According to UNDP (2001) the HIV epidemic is masked by the stigma attached to it and the denial it induces at the individual, family and community levels. Due to the HIV related stigma many are still reluctant to disclose their HIV status for feelings of shame associated with being HIV positive.

There are also traditional beliefs that HIV is *boswagadi*, a disease thought to afflict those who had sexual intercourse with someone else immediately after losing their spouse without first undergoing some ritual treatment. This diverts attention from HIV and encourages the continuation of risky sexual behaviour. This belief is common among the less educated adult population.

2.3.5 Alcoholism and Substance Abuse

People who abuse alcohol and other substances are more likely to engage in behaviors that place them at risk for contracting HIV. According to Petry (1999), a history of heavy alcohol use has been correlated with a lifetime tendency toward high-risk sexual behaviors, including multiple sex partners, unprotected intercourse, sex with high-risk partners (e.g., injection drug users, prostitutes), and the exchange of sex for money or drugs. There may be many reasons for this association. For example, alcohol may reduce inhibitions and diminish risk perception. Studies consistently demonstrate that people who strongly believe that alcohol enhances sexual arousal and performance are more likely to practice risky sex after drinking (Pentry, 1999; Kalichman et al, 2002).

Some people report deliberately using alcohol during sexual encounters to provide an excuse for socially unacceptable behavior or to reduce their conscious awareness of risk. According to McKirnan et al (2001), this practice may be especially common among men who have sex with men. This finding is consistent with the observation that men who drink prior to or during homosexual contact are more likely than heterosexuals to engage in high-risk sexual practices

(Avins et al, 1994). However, the association between drinking levels and high-risk sexual behavior does not imply that alcohol necessarily plays a direct role in such behavior or that it causes high-risk behavior on every occasion. For example, bars and drinking parties serve as convenient social settings for meeting potential sexual partners (Purcell et al, 2001). Alcohol increases susceptibility to some infections that can occur as complications of AIDS. Infections associated with both alcohol and AIDS include tuberculosis; pneumonia caused by the bacterium *Streptococcus pneumoniae*; and the viral disease hepatitis C, a leading cause of death among people with HIV (Cook, 1998).

It is generally believed that the progression of HIV and the development of AIDS-associated infections may be controlled by highly active antiretroviral therapy (HAART). Studies have associated heavy alcohol use with decreased medication compliance as well as with poorer response to HIV therapy in general (Lucas et al, 2002; Wagner, 2001). Furthermore, Studies show that decreasing alcohol use among HIV patients not only reduces the medical and psychiatric consequences associated with alcohol consumption but also decreases other drug use and HIV transmission (Lucas et al, 2002). Thus, alcohol and other drug abuse treatment

can be considered primary HIV prevention as well. The TCBP may have to consider targeting alcohol consumption, injection drug use and sexual risk reduction as strategy for HIV prevention programmes for students and teachers.

The laws of Botswana prohibit the sale of liquor to children under the age of 18 years. However, other institutions of learning like the university provide direct access to alcohol through sale alcoholic drinks in their tuck shops. Some families derive a livelihood from beer brewing. Students are exposed to alcohol at an early stage through participating in brewing. This involvement of students in beer brewing precludes their warning about its potential dangers such as risky behaviour once one is drunk.

2.4 The Impact of HIV/AIDS on the Education Sector

According to the Central Statistics Office (CSO), access to primary and secondary education has improved significantly between 1993 and 1999. Table 2.2 shows the Gross and Net Enrolment Ratios for 1993 through 1999. Public education in Botswana is free, except for expatriates. Free education has led to high enrolment ratios as depicted in the table below.

Table 2.2: Primary Gross and Net Enrolment Ratios

	GER* 7-13	NER* 7-13	GER 6-12	NER 6-12
Year	per cent	per cent	per cent	per cent
1993	114.0	95.1	114.1	85.7
1994	115.2	95.9	115.6	86.9
1995	116.2	96.7	116.6	87.8
1996	117.4	97.9	117.9	88.5
1997	118.3	98.4	118.4	89.2
1998	117.4	98.6	118.0	90.3
1999	117.8	99.5	115.6	89.0

SOURCE: CSO, Education Statistics, 1999.

*GER = Gross Enrolment Ratios and NER = Net Enrolment Ratios

GER and NER indicate the ratio of children who are in school to those who should be enrolled. The CSO used the following formulae to derive the ratios.

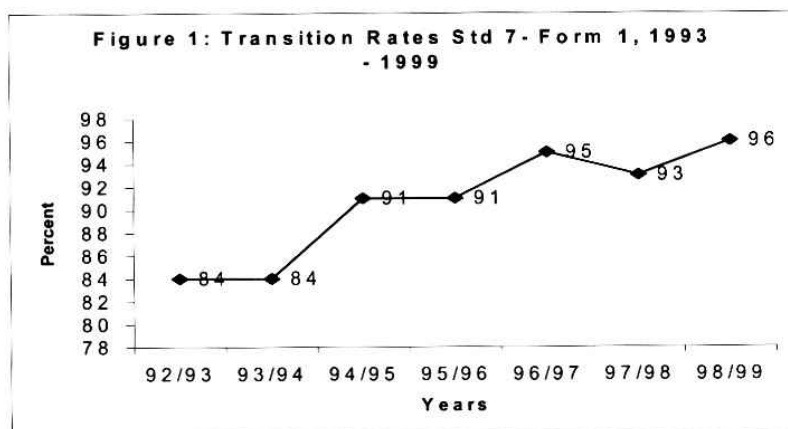
$$\text{GER} = (\text{Total enrolment} / \text{Population of specified age group}) * 100$$

$$\text{NER} = (\text{Enrolment of specified age group} / \text{Population of that specified age group}) * 100$$

The trend depicts growth in the GER and NER. The NER of 99.5 per cent, in 1999, indicates that only 0.5 per cent of children within the age group 7-13 are not enrolled. Some may already be at secondary schools, especially those from private English medium schools. The NER at 89.0 per cent indicates that about 11 per cent of the 6-12 year olds are not enrolled in the school system. This could be due to the fact that people in Botswana are used to children starting school at the age seven years and some could be schooling outside the country. A GER more than 100 per cent indicates that there are children outside the specified

age range who are enrolled. The transition rate from primary to secondary school indicates the increased access to secondary education, with about 96 % of primary school leaving pupils in 1999 getting access to secondary education (see chart 1 below).

A high incidence of HIV/AIDS among both teachers and students presumably should affect the performance of students, but this does not seem to be the case. Prolonged absence of both teachers and students from classes should negatively affect student performance, but to the contrary pass rates for primary and secondary schools have either remained the same (Form 2 and O' Level) or improved (standard 7) (GoB, 2001, p.18). In about half of the 19 survey schools, repetition and drop outs had increased insignificantly except for one school. Among the remaining other half, repetition and drop outs had actually declined (op cit). HIV/AIDS may have had an impact in the schools but the impact has been very limited. Primary school drop outs have declined from 6942 in 1998 to 6390 in 1999, a decrease of about 7.9 %. Illness constituted about 2.8 %, death represented about 1.8 % and pregnancy made about 2.2 %, altogether making about 6.8 % of the entire drop out reasons.



Source: Education statistics:1993-1999

These are very small proportions compared to other drop out reasons reported in 1999. However, drop out due to pregnancy indicates that sexual practices are going on among primary school going age. Desertion was the most common reason at about 87 %. It was also the only factor to have increased from the previous year's level. The desertions may include children who eventually have to be caretakers for their ill parents or relatives.

Table 2.3 Primary School Drop-out by Reason, 1998 - 1999.

	1998 Number	% Drop-out	1999 Number	% Drop-out
School fees	98	1.4	21	0.3
Expulsion	26	0.4	4	0.1
Illness	249	3.6	181	2.8
Death	114	1.6	116	1.8
Marriage	9	0.1	8	0.1
Pregnancy	212	3.1	142	2.2
Desertion	5,659	81.5	5556	86.9
Other	575	8.3	362	5.7
Total	6,942	100	6,390	100.0

Source: Education Statistics, CSO, 1999.

However, drop outs due to illness, death and pregnancy have slightly increased between 1998 and 1999 for secondary school students. Pregnancy rates remain very high for secondary school students at about 42 % of the entire drop out reasons in 1999, having increased from 39 % in 1998.

Table 2.4: Secondary School Drop-out by Reason, 1998 - 1999.

	1998 Number	% Drop-out	1999 Number	% Drop-out
School fees	217	6.6	154	4.3
Expulsion	17	0.5	40	1.1
Illness	102	3.1	129	3.6
Death	46	1.4	78	2.2
Marriage	21	0.6	5	0.1
Pregnancy	1,282	39.0	1,489	41.9
Desertion	1,248	38	1,438	40.5
Other	354	10.8	221	6.2
Total	3,287	100	3,554	100.0

Source: Education Statistics, CSO, 1999.

The rate of drop out due to pregnancy indicates that students at secondary schools engage in unprotected sex. Correspondingly the numbers of drop outs due to ill health and death have increased (see table 2.3). Desertions have also increased, but there are many reasons that may prompt a student to desert schooling. Among those reasons could be to take care of sick family members, illness and deaths which parents or guardians do not report to the school authorities.

The Ministry of Education conducted a study on “The Impact of HIV/AIDS on Primary and Secondary Education in Botswana; Developing a Comprehensive Strategic Response” in 2001. According to the study there seems to be a limited impact of HIV/AIDS on the overall learning outcomes (GoB, 2001, p. 19). Also, students sampled at the survey schools in both primary and secondary perceived HIV/AIDS not to be a serious problem with less than 15 % seeing HIV/AIDS as a major concern in their schools (op cit). Very few teachers interviewed, as well, perceived HIV/AIDS to be a serious problem. The report asserts that secrecy, uncertainty and denial influence the teachers’ perceptions. But there is also a lack of statistical evidence to indicate that the student and teacher populations are ravaged by HIV/AIDS.

2.5 National HIV/AIDS Prevention Strategy

2.5.1. National Strategy

HIV/AIDS presents one of the greatest challenges for Botswana in modern history. About 55% of patients in medical, general as well as paediatric wards had HIV/AIDS related conditions in 1998 (GoB, 2001). The first case of HIV/AIDS in Botswana was diagnosed in 1985. To date Botswana tops the list of countries that are severely affected by HIV/AIDS both in Sub-Saharan Africa and in the entire world. It is estimated that one in three sexually active adults in Botswana is HIV positive (BIDPA, 2002). The government responded with a number of approaches aimed at mitigating the spread and impact of HIV/AIDS. In 1986 the Ministry of Health established the Epidemiology Unit to screen blood and ensure sustainable supply of needles. In 1987, a 2 –year Short-term Plan was introduced, followed later by the Medium-term Plan I 1989-93, in 1989. The National AIDS Policy was adopted through a Presidential Directive in 1993. A Medium-Term Plan II, 1997-2002 was introduced in 1997. In 1997 the government established the National Aids Council chaired by the Minister of Health. The Council membership comprised government representatives, civil society and the private sector.

In 1998 the Parliamentary Select Committee on HIV/AIDS was established, and a year later the National Council on AIDS was reorganised with his Excellency the President as Chairman. In 2000 the government appointed the Coordinator of the National AIDS Control Agency (NACA). In 2002 the government started the Anti-retroviral (ARV) treatment to citizens infected with HIV.

The epidemic has caused extensive social and economic costs to the country. The Botswana National Policy on HIV/AIDS has adopted a multi-sectoral approach that acknowledges the private sector and NGOs as important stakeholders or role players. Article 4.16 of the HIV/AIDS policy outlines the role of NGOs and CBOs. And these are to:

- Develop and implement sustainable innovative HIV/AIDS prevention and care projects and activities, in line with the priorities articulated in the national strategic plan and integrate their services within the primary health care principles
- Mobilise communities for HIV/AIDS prevention and care activities which are affordable and sustainable
- Advocate for the involvement of various sectors of government, leaders at national, district and community levels, in HIV/AIDS prevention and care
- Coordinate among themselves as well as participating in national coordination activities to minimise duplication, and enhance the establishment of complementary programmes, projects and activities
- Mobilise resources for implementation for Community Home Based Care (CHBC) programme.

The role of the NGOs has further been enhanced by the inclusion of their parent/umbrella body, Botswana Network of AIDS Service Organisations (BONASO) in the National AIDS Council chaired by the State President.

The circumstances under which the National Policy on HIV/AIDS was made did not allow for broad consultations through *kgotla* meetings as is commonly done with other policies. It was mainly handled like an emergency and no time could be wasted bickering around who has to be consulted and who has not been consulted. The policy was issued as a Presidential Directive, CAB:33/98 dated 23rd September 1998. However, the implementation of the policy serves as best practice in view of the openness the policy has towards the participation of the NGOs and CBOs. The government coordinates the donations from the Bill and Melinda Gates Fund, and the implementers are the CBOs. Because the government structures do not allow for flexibility in some respects the CBOs and NGOs have actually come in handy to fill that gap. For instance, the fight against HIV/AIDS involves sexual and reproductive health. In this area the government clinics have been found to be less user-friendly for the youth.

And the consumption of their services has not been encouraging. On the other hand the Botswana Family Welfare Association (BOFWA), an NGO affiliated to the International Planned Parenthood Federation (IPPF) uses a strategy known as Peer Approach to Counselling by Teens (PACT) to convey some of its services. This programme is used to reach youths on issues including teenage pregnancy, sexually transmitted diseases.

BOFWA operates two youth centres in Gaborone and Lobatse (BIDPA, 2002). These run outreach programmes through seminars and workshops across the country to reach the target group. There has been a significant use of their services such as the distribution of condoms to the youth in a much more successful manner than do government clinics. The objectives of BOFWA are to:

- To provide the right knowledge and practice of Family Planning as a human right
- To collect and advance information on National, Regional, and International sexual and reproductive health (SRH) issues
- To advocate for the removal of barriers towards affordable SRH service Delivery, and with more relevance to children and youth in general:
- To operate as the leading NGO in adolescent sexual and reproductive health service

Although the centre is faced by high rates of turnover due to lack of funds to retain the peer counsellors, the contribution BOFWA continues to offer remains significant in the fight against the spread of HIV/AIDS. This case represents one of the best case examples in that it has the youth steering the programme. HIV/AIDS is common among the youth especially ages 15-25 years among females, and 25 – 45 among males. Teenage pregnancies are also a serious challenge for school going age, which BOFWA is specifically targeting. The use of BOFWA services has opened an avenue, which the government could not have been able to do on its own. Although the number of teenage pregnancies and the incidence of HIV/AIDS remain high, it would have been worse without the interventions of the civil society. A sense of worth and responsibility is created among the youth, as well as that of ownership of HIV/AIDS and teenage pregnancy mitigation.

2.5.2 The School Based Approach

The government has also developed school based HIV/AIDS prevention for students. The Ministry of Education (MoE) issued a policy statement on HIV AIDS in September 1998 (GoB, 2001). The objectives of the policy are as follows:

- HIV/AIDS should be integrated into education at all levels and made compulsory.
- Content and methodology should be age appropriate.
- All staff should share responsibility in HIV/AIDS education.
- In-service courses should be developed and impleted to disseminate information on HIV/AIDS.
- In-service curriculum and an implementation plan to be developed in collaboration with Ministry of Health.
- AIDS counseling should be included in the training of guidance and counseling teachers.
- PTAs and the community should be involved in AIDS education.

The MoE has adopted a policy of “integration and infusion” of HIV/AIDS in all subjects (GoB, 2001, p. 26). This approach has been adopted as result of the curriculum being said to be already overcrowded to allow a separate timetabling of HIV education as a separate subject. HIV/AIDS is first introduced at standard 7 where the aim is to describe how STDs and AIDS are caused, spread and how they can be avoided. At junior secondary school the HIV/AIDS topics are covered more profoundly in Moral Education and Science and is infused in the Art and Design and Technology curriculum. At senior secondary the coverage is less extensive as compared to junior secondary. The teacher training colleges had not introduced the HIV/AIDS topics in their curriculum by 2001.

Another strategy adopted by the MOE is guidance and counseling in schools. However, formalized guidance and counseling services and properly trained teachers were virtually non-existent in most schools (GoB, 2001, p. 27). Guidance and counseling curricula have been developed for CJSS and senior secondary schools, and guidelines for primary schools are being developed (op cit). The MOE has also introduced the Teacher Capacity Building Project for HIV/AIDS and STIs. The project goal is to:

- Contribute to HIV and AIDS prevention and mitigation of HIV and AIDS impact through strengthening the capacity of education and communication sectors in the provision of an interactive, distance education on HIV and AIDS for teachers and the objectives are as follows:
- Differentiate between HIV, AIDS and STIs.
- Protect oneself and others against HIV infection
- Manage personal sexual behaviour in ways that reduce the risk of HIV infection
- Be aware of the socio-cultural factors that fuel the spread of HIV/AIDS.
- Live responsibly in demanding and challenging areas of life.
- Live positively with HIV and AIDS.
- Respond appropriately to the needs of peers and children affected by HIV and AIDS.
- Be aware of human rights issues, their application in life and relevance to HIV.
- Develop life-skills for the positive social behaviour.
- Develop appropriate social attitudes and competencies for living positively within the HIV and AIDS era
- Address myths, prejudices, and misconceptions that facilitate the spread of HIV.
- Demystify and bring HIV/AIDS into the open
- Be aware of care and support issues to promote positive living
- Impart knowledge, attitudes, and skills that promote the prevention of HIV infections.

The main aim of the TCB project is to empower teachers with the knowledge, skills, and attitudes which will enable them to behave in a responsible way and be able to effectively deal with HIV and AIDS issues in schools and in the community (Branco and Moanakwena, 2003). A curriculum has been developed for teachers at primary, secondary and tertiary education levels, which would contribute to the protection of the next generation referred to as “window of hope”. The rationale is that “children and young people have the right to knowledge and understanding, and therefore must have access to the full range of information and resources on HIV and AIDS, including how to use condoms and other preventive measures, that will prevent themselves and others from getting infected” (op cit, p. V). The

MoE through the Department of Teacher Training and Development has introduced the Training of Trainers Course on Interactive Teaching Methods for the TCB project. The main aim of the course is to empower teachers to deal with HIV and AIDS in their work environments and to effectively teach the young generation, through the use of interactive teaching methods, behaviour that will promote the prevention of HIV infection (GoB 2003).

2.6 The Teacher Capacity Building Project

In response to the HIV/AIDS epidemic, the Government of Botswana has through the Long Term Vision for Botswana, Vision 2016, purposed to combat the spread of the HIV virus (Vision 2016, 1997, p.52). The Government has intensified its campaign against HIV and all available media of communication are being exploited. HIV prevention has spread to schools but now the Government wants to enhance the capacity of teachers to effectively deliver the HIV/AIDS prevention message in schools as part of “the national objective of achieving an AIDS free generation by 2016 (TCB¹).

The school going age in Botswana ranges from 6 to about 24 years. This includes primary (6 – 13) secondary (13 – 19) and tertiary (16 and above). According to the UNAIDS adults include the age group 15 – 49 years. However, the age range defining an adult cuts across the school going age. In the rural areas it is not uncommon to find primary school children aged around 15 years or above due to issues related to access and others that cannot be discussed in this report. In view of this scenario, HIV/AIDS is definitely a problem for children and adults in school. Also, Botswana is a developing country with limited skilled labour that is desperately needed for policy implementation. The preservation of the educated labour force against HIV is of paramount importance. The potential macroeconomic impact that HIV/AIDS could have on the national can be devastating. Awareness creation about how HIV/AIDS is perceived to be one of the potent weapons against the disease.

The TCBP is a South-to-South cooperation between Governments of Botswana and Brazil in HIV/AIDS prevention. This project is modelled around the Brazilian experience where major inroads on combating HIV/AIDS were made through the use of distance education to train teachers through the use of TV and IT. Botswana has a committed leadership with a goal of having an HIV/AIDS free generation by 2016. In line with this goal, the TCB project is intended to contribute to the GoB’s strategic framework. The main objectives are to contribute to the achievement of behavioural change in teachers and students through improving on teacher’s knowledge base, demystifying and destigmatising HIV/AIDS and breaking down cultural practices associated with sex and sexuality.

¹ Teacher Capacity Building Project for HIV/AIDS Prevention: Project Briefing Notes.

The project focuses primarily on the teacher with student being the secondary target. The project employs interactive TV broadcasting and information and communication technology (Information Technology). A key component of this programme involves the development and implementation of an audio visual HIV/AIDS prevention curriculum in schools throughout Botswana.

The curriculum will focus on socio-cultural and gender issues relevant to young people. This is in line with the Ministry of Education's sectorial change in learners and staff through Behavioural Change Communication strategies which is aiming at enhancing understanding of sexual reproductive health issues to prevent the further spread of HIV infection and reduce denial, stigma and secrecy surrounding HIV/AIDS. This strategy is different in that it directs the search for viable policies and action inside Botswana itself. The curriculum approach has entailed reforming formal curricular to incorporate HIV/AIDS as an integral part of others such as biology, health and hygiene, family life education, guidance and counselling, and social studies. The assumption behind integrating HIV/AIDS issues particularly at primary level is that most pupils are not yet sexually active and so it is essential to alert them to the dangers and consequences of sexually transmitted diseases, some of which are deadly, such as HIV/AIDS. This is hoped to instil competence and confidence among children so as to enable them to avoid or manage risky situations and at the same time to enable them to control situations and make informed choices.

The extra-curriculum approach to HIV/AIDS is characterised by a variety of activities organised by teachers, pupils, and/or NGOs. Although many of the activities are classified under the rubric of peer education, the mechanics and process of implementation differ widely. Extra-curricular activities are organised in forms of school health clubs, school environmental clubs, Scripture clubs, HIV/AIDS clubs, and school drama clubs. Most of the extra-curriculum programmes are designed to be led and/or implemented by peers. Peer education is undoubtedly one of the inherent strengths of extra-curriculum programmes and TCB project is designed to use more interactive learning rather than the more traditional teacher-pupil (chalk-and-talk) programmes.

3.0 RATIONALE FOR THE STUDY

It is important to have sufficiently accurate and complete data regarding the knowledge, perceptions about spread of STDs/HIV/AIDS in order to plan and implement an effective prevention and control programme. United Nations Development Programme (UNDP) and MOE have collaborated to carry out a baseline study on knowledge, attitudes and perceptions about HIV/AIDS among teachers and students among selected schools where the TCB project is going to be piloted. The aim of the study is to obtain baseline on extent of knowledge, misconceptions and attitudes about STDs/HIV/AIDS in Botswana in order to develop effective and integrated strategies for prevention and control.

The data and insights from the baseline inquiry are intended to be subsequently used to assess the impact of the TCP project intervention. Consequently, the baseline survey, whose findings are reported below sought to find out the pre-intervention situation among students and teachers on knowledge of STDs (including HIV/AIDS), depth and correctness of information held on HIV/AIDS, knowledge of STDs and HIV/AIDS prevention personal HIV/AIDS-risk perception, condom knowledge and acceptability and recent sexual behaviour. Specifically the objectives of the TCB project baseline study are:

- To provide information on the level of knowledge, attitudes and practices of teachers and students in relation to HIV/AIDS;
- To explore views and perceptions of school youth in relation to HIV/AIDS myths, beliefs, stigma, denial and secrecy;
- To provide a baseline that will form a basis for project monitoring and evaluation and to identify the needs and priorities of the target group.

An achievement of these objectives will provide insights into issues of risk, risk reduction, HIV/AIDS knowledge and communication, psycho-social and socio-cultural aspects of HIV/AIDS, providing important baseline data for monitoring and evaluation as well as future interventions.

4.0 METHODOLOGY

Ministry of Education has selected 105 schools to be used in the study. This represents 10% of all the schools, primary, junior secondary, senior secondary, College of Education and technical colleges. The selected schools are geographically widespread around the country. The sample was selected as follows:

4.1 Primary Schools

For the Primary schools we assumed that sexually active students are those aged from 12 and upwards. And, most of these pupils are in standard 5, 6, and 7; hence the sample will be selected from the above standards. Also, with the assumption that the total number of pupils is equal in all the standards, the Sample Size, n , was calculated as follows:

$$n = \frac{3}{7} \times 0.2 \times N$$

$\frac{3}{7}$ Is the fraction of standards 5, 6, and 7. (For according to our assumption, each standard is $\frac{1}{7}$ of the whole school population, hence $\frac{3}{7}$ because of the three standards taken) where 0.2 is the 20% of the sexually active students. This ensures representation of the population in question. That is, only 20% of the students from standard 5, 6, and 7 was involved in the survey. N is the total school population. After calculating the sample size, a Proportionate Stratified Sampling method was used to select the sample. The students were stratified according to their Standards; and then a Stratified Random Sampling method with a uniform sampling fraction was used to select the sample.

4.2 Junior and Senior Secondary School Students

It was generally assumed that all the students in secondary schools are sexually active. All the students were included in the sample selection process. The sample size was selected as follows:

$$n = 0.2 \times N$$

After calculating the sample size, a Disproportionate Stratified Sampling method was used to select the sample. The students were stratified according to their forms; and then a Stratified Random Sampling method with a variable sampling fraction was used to select the sample. Disproportionate stratified sampling was used because of the following reason;

Form 1's and 4's are still new to the schools, so they may not be able to give more information as those who have been at the school for a longer period. So, the study will have more students from form 2 and 3 classes in junior schools and form 5's from senior schools to be included in the sample.

4.3 Colleges of Education and Technical Colleges

Since it is assumed that all the students in tertiary schools are sexually active. All the students were included in the sample selection process. The sample size was selected as follows:

$$n = 0.2 \times N$$

After calculating the sample size, a Disproportionate Stratified Sampling method was used to select the sample. The students were stratified according to their year of study; and then a Stratified Random Sampling method with a variable sampling fraction was used to select the sample. Disproportionate stratified sampling was used because of the following reason;

Year 1 students are still new to the schools, so they may not be able to give more information as those who have been at the school for a longer period. Therefore, more students from year 2 and upwards included in the sample.

4.4 Teachers and Head Teachers

The study covers all the head teachers and teachers from the selected schools. In a situation where the head teacher is not around, the acting Head filled the questionnaire (Appendix F). The over all sample size for the study was 7440 students and 3053 teachers (A, B, C). A self administered questionnaire was filled by all the above groups.

4.5 Focus Group Discussions

Apart from the self administered questionnaire, there were also the focus group discussions (Appendix G). From each school the enumerator is expected to have about one to three focus groups of at-least ten students. The focus groups was selected as follows:

One group will consists of both *boys and girls*, and this has to be equally balanced gender wise. The other one will consists of *boys only* and the other will consisted of *girls only*.

5.0 DATA COLLECTION, PROCESSING AND ANALYSIS

5.1 Data Collection

Data was collected from students, teachers and school administrators as well as community leaders who are directly involved with schools. Focus group discussions were held with students. Focus groups are facilitated group discussions using scripted questions that are generally populated by a homogenous audience of interest to the researcher. In most cases (including this one), focus group studies are qualitative in nature. Qualitative data can be analyzed to uncover a range of perspectives and themes on a given subject. But the small sample sizes and non-random selection of participants prevent using the findings to draw cause and effect relationships or to generalize the results to the wider population from which the participants were taken. Still, in a few instances, the results may describe a dominant or a widely held or expressed opinion where there was consensus around some idea or issue. Focus groups do lead to important insights about topics and allow the facilitator to probe a group's thinking on matters both scripted and that arise spontaneously through conversation. This feature makes it a more flexible tool than quantitative surveys. Focus groups are also advantageous when compared with conducting one-on-one interviews because they allow participants to feed off of one another's ideas and spark thoughts that may not have been captured in isolation.

For this study, groups consisting of boys and girls, as well as those constituting of girls alone and boys alone were held. The study ensured that different class standards are represented in these groups. The focus group discussions gauged students' knowledge on the causes of HIV/AIDS as well as knowledge of its symptoms. Issues of inter-generational sexual engagements as well as the role of peer pressure in the spread of HIV/AIDS were also explored during focus group discussions. Similarly, the role and influence of the social environment as well as the role of cultural practices and beliefs were assessed through focus group discussions.

Discussions with school heads were held to establish the type of strategies for HIV/AIDS that are currently in place. This was augmented by interviews with one member of the PTA, in

most cases the chair-person. Teachers were mainly interviewed to establish whether they have any knowledge on Interactive Teaching Approach with the view of establishing whether they apply it to increase student's AIDS awareness.

To collect quantitative data separate questionnaires for students and teachers were designed and the individuals completed these confidentially. A qualitative questionnaire was also designed for school heads to provide information on enrolment rates, drop-out rates, number of deaths in the school that occurred during 2002 as well as figures on levels of absenteeism etc. The questionnaire for student was meant to tease out issues of sexual activities, such as first age of ever having sex, use of condoms, relations, knowledge on symptoms and causes etc.

5.2 Data Analysis

Standardisation and uniformity during the survey were ensured by training research assistants. All teams were briefed and debriefed during the phase of data collection. Data entry was done in the excel package while the final data analysis was done using the SPSS (11.5) software. Adequate checks were built in at data entry and data analysis stages to ensure data quality.

The baseline data analysis consists mostly of frequencies and cross tabulations. To determine the significance of the difference in characteristics between different types of research participants (e.g., teachers versus students), the researchers conducted cross tabulations and chi-square analyses. A p -value of less than 0.05 was used as the threshold for significance.

5.3 Limitations and Problems

The survey targeted about 7439 students, 3053 teachers and about 105 headmasters. However, about 5647 students responded which is about 76.4 percent with 25.6 percent non-responses (Table 2.5). As for teachers the situation was much gloomier with 56.7 per cent responding and a significant 45 per cent refusals and non-responses. The actual sample comprised:

Table 2.5 Scope of the Study

Type and Number of Schools	Number Selected	Number Interviewed
76 Primary schools	3350	3124
22 Secondary schools	3283	1890
8 Tertiary Institutions	757	633
Total 106	7439	5647
Teachers	3053	1731

The headmasters' response rate was relatively good at 70.5 per cent with 29.5 percent refusals and /or non-responses. Non-responses included refusals, unexplained absences and legitimate absences such as attendance of conferences and official meetings, etc. nonetheless, there were several other limitations that impacted on the study. First, there was a lack of cooperation especially from the lecturers and the sampled colleges of education as well as from students in the colleges of education. Similar problems were experienced with some senior secondary school teachers.

In about 40% of the secondary schools, researchers had to reschedule their programme to suit that of schools. In most cases researchers could not conduct the study during teaching time or on sports days. This delayed the field work especially that the schools were not concentrated in one area. Also, the data collection exercise coincided with the Teacher Capacity Building Project's HIV/AIDS workshops. Because of this, some of the teachers responsible for the coordination of HIV/AIDS activities in schools were away attending workshops. Those remaining behind were reluctant to offer assistance to researchers. This development resulted in some delays and inefficiency in data collection.

The addition of more questions by the client to the original questionnaire when the data collection exercise had already started created some problems both during the data collection and later during the data analysis. It was tedious to manually insert questions in the questionnaire while in the field. As for analysis, there were inconsistencies in the data set given that some questionnaires did not have the variables that were added at a later stage as the interviews had already taken place in some schools at the time of adding the extra questions. This has led to some difficulties in the data processing and analysis, as well as in interpreting the results.

In some regions primary school pupils had difficulty completing questionnaires which were written in English. In some cases pupils could not write comprehensively in both Setswana and English. The wording for some questions was too technical to the extent that even teachers had difficulty understanding what the questions really wanted, without seeking assistance from the researchers (the questionnaires were self administered). In cases where the respondents had to frequently seek assistance confidentiality was compromised and in view of the nature of the information being sought some respondents would be shy to ask for help or clarification. Under such circumstances valuable and truthful information is not captured.

The researchers also experienced problems related to lack of cooperation from some teachers. The problem was common among secondary school and tertiary school teachers. For example, at Kgari Senior Secondary School, out of 81 teachers only 41 returned their questionnaires. Among those who returned the questionnaires most did not answer all the questions. Some teachers also at primary level refused to complete the questionnaires. For example, Lephalleng Primary School in Kweneng and Rasesa Primary School in Kgatleng. Failure to complete the questionnaire may have stemmed from perceptions that one may lose their job. Many teachers indicated that they suspected the Government to be trying to find out about their HIV status so that if they are found to be positive they would be fired.

6.0 RESULTS AND FINDINGS

6.1 Observations from Focus Group Discussions

This section discusses the focus group interviews conducted among primary schools, secondary schools, teacher training colleges and vocational education institutions. The schools in which the interviews were conducted are listed in Appendix A, B and C. The aim of conducting focus group discussions was to complement the statistical data by exploring views, perceptions and beliefs of student groups in the sampled schools in relation to HIV/AIDS. Focus group discussions enabled the researchers to probe further on questions and to give qualitative data that may not be easily captured in a statistical questionnaire.

On the assumption that the students' perceptions and level of understanding of HIV/AIDS varies according to level of education, the discussions have been divided into three components. That is primary, secondary and tertiary institutions. The findings of the focus group discussions are discussed below:

6.2 Knowledge about HIV/AIDS and Sources of Information

All students indicated that they know about HIV/AIDS with many indicating that they have heard about it from clinics, hospitals, home (parents, relatives), friends, schools, television, books, magazines and radios. The Tebelopele Testing Centres and the Total Community Mobilisation Teams (TCM) were also mentioned as sources of information. However, potentially important sources as newspapers were not commonly mentioned as key sources. The mention of newspapers unlike with other sources was rare. Television also, although an important source of information for some, did not come out prominently in villages far away from the main centres. This is explained by the level of development of some of the areas that were visited. Most of the schools are in the outskirts of bigger villages and towns. The coverage of the newspapers in such areas is limited and in some cases non-existent, especially the private newspapers. Further, some of the villages have no electricity, or were connected with electricity very recently, thus television is not found in most homes.

Very few groups mentioned having heard about HIV/AIDS from the *Kgotla*. This should be explained by the fact that in the Botswana society, the *Kgotla* usually provides fora for the older folks. People of the students' age usually visit the *Kgotla* on special occasions such as independence celebrations. Therefore, even if the *Kgotla* may be exposing more people to information about HIV/AIDS, it is very rare that the students would be present at such gatherings. The *Kgotla* plays a limited role in disseminating HIV/AIDS information to students except during commemorative events like the World AIDS Day.

In general students were knowledgeable about how HIV/AIDS is communicated from one person to the other. The most common answer given by them was 'having sex without a condom'. Other answers included the sharing of sharp objects such as injections and razor blades, helping infected persons without the use of gloves resulting in contact with infected blood or body fluids, and promiscuity. However, there were some students who believe one can contract HIV/AIDS by kissing, sharing meals, sharing utensils and touching an infected person. A few believed that the HIV virus is airborne since they intimated that one has to avoid the cough of an infected person.

6.2.1 HIV/AIDS Prevention and Testing

Most students understood very well the HIV/AIDS prevention approach commonly referred to as ABC; abstain, be faithful and condomise. Most indicated that to avoid contracting HIV/AIDS one has to abstain from sex, use a condom and being faithful to one's sex partner. However, their understanding seems to go beyond the ABC approach to include general precautions about interacting with infected persons. These include the use of hand gloves when handling an HIV/AIDS patient, which shows that students know the risks involved in caring for infected people. It also indicates that students know that the HIV virus can be communicated through body fluids, hence most expressed reservations about playing with an infected person. But where some indicated they could play with somebody who is HIV positive they would add that they would exercise caution not to come into contact with their blood.

Students were knowledgeable about where to go for HIV test. Tebelopele Voluntary Testing Centres and medical facilities were mentioned as places where one could go for a test. Even those in places far away from the Tebelopele Testing Centres were aware of the services

offered by these facilities. In very limited instances, which occurred only among primary school pupils, did students suggest that one may consult a traditional doctor to know their HIV/AIDS status. As for secondary schools and tertiary institutions the role of traditional doctors in determining one's HIV/AIDS status was never raised, indicating that the older persons do not have confidence in traditional doctors as far as HIV/AIDS is concerned. All groups expressed the opinion that all sexually active individuals should go for an HIV/AIDS test. There were some specific categories of people mentioned as those who should go for the test and these are; parents, those who suspect they might be infected, youths, teachers and those interested in knowing their status. Some students, especially males said it should be women who must go for HIV testing, while female students suggested it should be men who should go for the test.

The most common reasons given for testing throughout the schools were: to know one's status to avoid the spread of the virus, to plan for future family, to get appropriate help in good time should one test positive, and also that caretakers such as relatives could assist accordingly without endangering their own lives.

Reasons for not testing included: fear of discrimination, denial, and fear to know of certain death. Another answer from the respondents was that people simply feared knowing their HIV status. Some feared that they would not know what to do once they have tested positive. These answers indicated that most people are still not comfortable going forth for voluntary testing. It may also be indicative of the limited knowledge, or absence of knowledge, about the counseling aspect of the test, among primary school students.

6.2.2 HIV/AIDS Symptoms and Unprotected Sex

Although most students said they have never seen somebody suffering from AIDS they mentioned the following common symptoms of HIV/AIDS:

- Loss of weight
- Sores/wounds all over the body
- Fluffy hair and loss of hair

- Chronic illness involving various ailments (i.e. generally weak immune system resulting in many opportunistic ailments such as Tuberculosis)
- Darkening of skin colour
- Continuous diarrhea
- Chronic headache
- Excessive sweats
- Chronic fatigue
- Loss of appetite, and
- Blisters in mouth and lips (ditatswa)

The symptoms were consistent through all the schools except for lip blisters (ditatswa) which was mentioned in a few schools.

All focus groups described unprotected sex as 'sex without a condom'. Promiscuity was also mentioned among the activities related to unprotected sex. In addition students mentioned sex with somebody one does not know their status, and also sex with an infected person. In one primary school in the Southern District students said unprotected sex is having sex with small children. This shows that primary school children are aware of the dangers of intergenerational sex and child molestation. In general, irresponsible sexual behaviour was pointed out as predisposing individuals to the risks of HIV/AIDS.

When asked who should take precautions during sexual intercourse most students said it should be everybody's responsibility. However, children in schools further away from Gaborone said it should be women who should take precautions. This kind of thinking could have been influenced by the association of sexual intercourse with pregnancy rather than thinking of prevention of Sexually Transmitted Diseases (STDs) and HIV/AIDS during the act. In the Kweneng, Kgatleng and Gaborone areas for example, there was a 50:50 split among the mixed groups, with boys saying girls should take the precautions while girls felt it should be both but stressed that it should be girls in particular. In the same areas, boys' only groups felt it should be both partners who should take the precaution. Since these areas are within closer proximity to the city, hence the availability of educational resources, the children in these areas seemed to have an opinion that is somewhat gender balanced.

6.2.3 Condom Access and Sex Education in Schools

Most students in primary schools are aware of access points to collect condoms. The most common places suggested included clinics, hospitals, shops, pharmacies, offices, hotels, bars, tuck shops, Tebelopele Voluntary Testing Centres and Botswana Family Welfare Association (BOFWA). However, primary school children complained of the attitude of teachers, parents and society in general concerning their access to condoms. Students complain that they are often denied condoms on the grounds that they are too young. In all primary schools pupils indicated that condoms are not availed to them by the school authorities. Some, however, especially standard five pupils, said they do not need condoms because they are still too young to engage in sex. The denial by society that their children are sexually active and the consequent refusal to allow them condoms has led to children engaging in very risky behaviour. Although limited to some schools in the Southern region, some pupils for example, indicated that due to lack of condoms they improvise by cutting out 'fingers' from hand gloves which they then use as 'condoms'. They said they insert the 'finger' over an erect penis and tie it around with wool or some other material. Some indulge in unprotected sex as a last resort. Refusal by parents to allow children access to condoms does not guarantee abstinence on the children's part but leads to frustration and unprotected sex despite the full knowledge of the risks involved. In all primary schools and some junior secondary schools, the boys' only focus groups said the condoms are too big for them. Consequently they do not use them out of fear that they might get stuck in their girlfriends' bodies.

Sex and HIV/AIDS education is not common in schools and in some cases where it is offered, students feel the information provided is inadequate. However, there are exceptions like Rasesa, Segopotso, Bakgatla and Thamaga primary schools where students felt that the sex education they received was adequate. This suggests that the quality of HIV/AIDS information varied from school to school. The limited availability of HIV/AIDS information in schools is also influenced by the almost absent or inactive HIV/AIDS clubs in schools. Students suggested the following factors as reasons for their dissatisfaction with their schools' HIV/AIDS information:

- There are not enough teaching materials about HIV/AIDS
- Available resources such as TV's are underutilized

- School children not encouraged to join HIV/AIDS clubs in schools
- Teachers are either not conversant with, or they are uncomfortable talking about, sex and HIV/AIDS with school children.

Students suggested that to improve Sex and HIV/AIDS education in their schools, HIV/AIDS clubs should be formed in their schools or where clubs exist they should be revitalised, condoms should be provided in schools, use TV and videos as teaching aids, school visits from HIV/AIDS educators, teachers should be more open and frank when dealing with HIV/AIDS issues in class, and that posters should be displayed around the schools.

6.2.4 Stigma

Ignorance which leads to inaccurate beliefs and myths about HIV/AIDS was more prevalent among students found in very remote areas such as Ukhwi, Middlepits, Metlobo, Mabutsane and many other villages in the remote areas of the Central District, Kweneng and North West districts. Some students in these areas believe that HIV/AIDS is airborne and that they will find it difficult to interact with fellow students who are HIV positive or with AIDS. The HIV/AIDS stigma seems strongest in remote areas and less so in the urban centres, especially Gaborone. For example, 90 percent of students in Gaborone indicated that they can interact with HIV positive persons, whereas the percentage gradually falls to about 10 % in remote areas. This could be as a result of the openness of parents and teachers in Gaborone as opposed to the more conservative parents as one moves further away from Gaborone.

6.2.5 Perceptions from Secondary Schools and Tertiary Institutions

The level of understanding among secondary and tertiary level students and the manner in which they articulated the issues differed from those at primary school level. However, the basic knowledge about HIV/AIDS with those at primary schools remained the same. But misconceptions were prevalent at primary and very limited at Community Junior Secondary Schools and almost absent at Senior Secondary Schools and tertiary institutions. Students at these levels were much more open and forth coming with information than primary school children. Everybody in these institutions indicated that they knew about HIV/AIDS. The

common sources of information were similar to those at primary, however, at these levels students said they got information mainly from books, newspapers, television and schools. Perhaps this also indicates the accessibility of reading material and sheer interest in reading at upper levels of the educational rung. Female students also mentioned their boyfriends as sources of information about HIV/AIDS.

Students mentioned unprotected sex, unscreened blood transfusion, mother to child transmission, breastfeeding and the sharing of sharp objects are possible ways of contracting HIV/AIDS. They mentioned abstinence, being faithful and condomising as possible ways of preventing the spread of HIV/AIDS. However, in spite of knowing the dangers of unprotected sex students at secondary and tertiary schools indulge in reckless sexual behaviour. The younger ones, especially CJSS students complained about the large size of condoms. Those in boarding schools said access to condoms is severely limited and find abstinence an impossibility. They argue that they are allowed to go for shopping once in a while and that is when they get the opportunity to buy condoms. The following reasons were raised by secondary school students as reasons for indulging in risky sex:

- sometimes they don't have money to buy condoms
- attitude of adults at condom access points is a deterrent in that they are often asked what they are going to do with the condoms at their age
- in boarding schools students are allowed only to go shopping once a month and in the interim they run out of supplies
- officially they are not allowed to have relationships and therefore it is difficult for them to ask for permission from teachers to go and buy or collect condoms from shops or clinics respectively.
- In the rural areas young people are usually scornfully turned back by the nurses when they ask for condoms from public health facilities.

However, students at tertiary institutions do not have problems accessing condoms since most of them are grown up. But they nevertheless engage in unprotected sex for the fun of it. Shyness was also mentioned as an inhibitor to access to condoms even at this level.

Students at this level were fully aware of the ways they could use to prevent HIV/AIDS infections. Besides the common 'Abstain Be faithful and Condomise' approach they

mentioned masturbation as well. However, most students said the use of condoms is the most effective preventive method as compared to abstinence and being faithful to their partners. Students showed a more superior level of understanding issues related to HIV/AIDS as they would not only talk about condom use but proper usage. However, students complained about the negative behaviour of nurses towards them, in public clinics and hospitals, whenever they come asking for condoms. Moreover, some of the nurses are their relatives such as aunts and they do not feel free to collect condoms in their presence. It is customary in Botswana for parents not to discuss sexuality matters with their children or younger relatives. Consequently, younger students feel uncomfortable to ask for condoms where their older relatives work. In a way they think they would have inadvertently divulged to their 'parents' that they are sexually active.

Students in some secondary schools indicated that they have peer counselling skills but the schools do not provide an environment in which these skills could be utilised for the benefit of their peers. They suggested that the problem of unfriendly public health facilities towards youths could alternatively be addressed through peer counselling. The lack of a conducive peer counselling environment was blamed by students on the absence of any working relations between public schools and organisations such as Botswana Family Welfare Association (BOFWA).

Testing for HIV/AIDS was found to be desirable by all groups since it allows them to know their status. Reasons advanced for going for an HIV/AIDS test included the following:

- to take better care of oneself if they happen to be infected
- to plan their future (e.g. marriage)
- to protect us from the spread of the virus

The negative behaviour of nurses also impacts negatively on the use of testing facilities in public clinics and hospitals. Most prefer to test at the Tebelopele testing Centres where they also feel the confidentiality of their test results is guaranteed. There are also limitations to testing for HIV/AIDS among the younger student population because of the following reasons

- they do not want to be seen at testing centres lest people think they are infected
- they are afraid to be associated with HIV/AIDS
- they are afraid of the questions asked at testing centres, they feel the questions are rather chasing people away instead of attracting them to testing centres
- fear for lack of confidentiality at testing centres
- they are afraid of parents if they are under 18 years of age: their parents may think they have engaged in sex if they ask for their company to the testing centres.

The fear of stigmatization is the predominant reason given by youths why people do not go for HIV/AIDS testing. Among the other reasons advanced for not testing are:

- Divorce or loss of a partner if one tests positive
- Fear to commit suicide if they find the results unfavourable
- Some fear because they have a bad sexual history
- Others see no need to go for a test because their sexual lives are clean and therefore are less likely to be positive
- Fear of being a social outcast

Both male and female groups generally thought everybody should go for a test but that since women are the most vulnerable they should be the ones going for tests. On the issue of who should take precautions during sex, most students suggested that both partners should, especially ladies since they are predisposed and they might fall pregnant.

Secondary and tertiary level students also expressed disappointment at the sex and HIV/AIDS they receive from their schools. The information was described as generally inadequate and lacking whilst teachers were said to be shy when they teach the subject. AIDS clubs are also said to be not well supported by the schools' administrations. Students at tertiary institutions never turn up for HIV/AIDS activities thinking that they know about it. Students suggested that the information could be improved by:

- giving AIDS clubs more support,
- peer education should be encouraged, for example through AIDS clubs,
- invite external resource persons,

- include practicals like visiting hospitals to see AIDS sufferers,
- a change in the moral behaviour of students
- videos should be shown to students
- introduce lessons on HIV/AIDS, and
- that teachers should be equipped with the necessary skills to handle the subject.

6.2.6 Sexual Behaviours, Attitudes and Stigma

The limited availability of condoms in schools, the negative attitude of health workers and lack of self control among students combine to create a conducive environment for the spread of HIV/AIDS among the youth. Serial and multiple sexual relationships are so prevalent in secondary and tertiary schools to the extent that some have dubbed it 'free fall'. According to some students wanton sexual behaviour continues unabated in spite of the full knowledge of the consequences thereof. A majority of students, at all levels, said they have multiple partners. It is not uncommon for students to have multiple sexual partners both inside and outside of their schools. Boys take pride in having as many girl friends as they can, while girls find it opportune to have extra boy friend just in case the main one dumps her. All these could be attributed to peer pressure. Peer pressure could be very destructive if not managed. Most schools, for example, address HIV/AIDS sporadically especially when there is a pregnancy in school. Some students feel that they could help in the fight against HIV/AIDS since they are peer educators. However, there is no forum in their institutions to address fellow students.

However, it is worthy to note that it is not all that gloomy. Some students at secondary indicated that they have not yet had sexual intercourse. This suggests that the opportunity still exists to encourage many students to delay sexual intercourse as well as to provide them with the education and resources to make the safest sexual choices in the future.

6.2.7 Conclusion from Focus Group Discussions

Students at all levels of education involved have heard and know about HIV/AIDS. However, although there seems to be no discernable difference in the basic knowledge about HIV/AIDS, the level of comprehension and accuracy of knowledge increases with the level of education. Misconceptions seem to be common in primary schools but not so at the higher levels of education.

Students at all levels generally knew how HIV/AIDS is communicated, as well as being familiar with the ABC approach to the prevention of HIV/AIDS. Nonetheless, risky sexual behaviour persists mainly due to limited access to condoms and weak morals. Abstinence and faithfulness to one's partner are moral issues and their achievement is dependent on one's moral integrity.

Most students, at all levels, knew the purpose of testing for HIV/AIDS, and where to go for a test. However, many did not view public health facilities favourably. Tebelopele Voluntary Testing Centres were preferred for their 'user friendliness'. These testing centres are widely known even in places where they do not exist. Public health facilities are hostile to youths, and schools do not have any working relations with youth friendly organizations like BOFWA. Peer counselors in schools are not utilised at all. This leaves the majority exposed to the vagaries of peer pressure.

No students, except a few at primary schools, mentioned the role of traditional doctors in testing for HIV/AIDS. This indicates that the awareness of the limitations of traditional medicine practitioners is increasing.

HIV/AIDS symptoms are well known to all groups. Most students also knew what unprotected sex meant, 'sex without condom'. But others included also other risky sexual behaviours as unprotected sex.

Condoms are virtually inaccessible to primary students and younger secondary school students. Condom access to the relatively senior secondary school students is at best occasional, but also students have to do it clandestinely to bring the condoms on campus.

Otherwise condoms are universally accessible to adults in Botswana, hence at tertiary level there are no problems of accessibility except those that are self-imposed such as shyness to pick one.

Sex and HIV/AIDS education was perceived to be unsatisfactory by a majority of focus groups interviewed. The teachers' inability to articulate HIV/AIDS issues and their perceived discomfort when handling the topic have contributed to the not so effective delivery of the HIV/AIDS information. The teacher problem is coupled with the lack of resources and, where available, their underutilization in disseminating HIV/AIDS information to students. HIV/AIDS clubs are either dysfunctional or non-existent in most schools visited. This has also contributed to limited information on HIV/AIDS.

Stigmatisation of HIV/AIDS remains a problem especially among remote primary school students. In places where stigmatization was strongest inaccurate knowledge, beliefs and myths about HIV/AIDS prevailed. In some of the far off primary schools the HIV virus was even thought to be air borne and also that it could be communicated merely through touching. The more accurate the knowledge about HIV/AIDS the less stigmatization there was. Even those knowledgeable occasionally succumbed to societal pressure as portrayed in many's fear to be seen at testing centres lest they be thought to have HIV/AIDS as well. More information is needed to combat both ignorance and stigmatization of the disease.

6.3 Headmasters Views

6.3.1 Introduction

As custodians of the Educational System, Headmasters were interviewed to provide vital information on the impact of HIV/AIDS on the school system. They provided information on total enrolments, and the extent to which both students and teachers are being affected by the epidemic. Information on school based programs against HIV/AIDS as well on how schools were conversant with the Interactive learning technique and their knowledge of the TCB project were also collected through this medium. The section that follows below summarises the findings on these aspects.

6.3.2 School Statistics

The strength of an educational system, in terms of its ability to use Interactive Learning methods to address issues of HIV/AIDS, is clearly correlated to the use of both qualified and unqualified teachers by the school system. It was in this regard that information on qualified teachers was collected. The table below captures the picture

Table 6.1 Number of Unqualified Teachers

Number of Unqualified Teachers	Schools Categories				Total
	Primary Schools	CJSS	SSS	Tertiary	
1 - 5	39 95%	7 70%	4 100%	0	50 89.2%
6-10	2 5%	3 30%	0	0	5 8.9%
16-20	0	0	0	1 100%	1 1.8%
Total	41 100%	10 100%	4 100%	1 100%	56 100%

According to the data that were collected from Headmasters, 100 out of 1043 Primary School teachers were unqualified yielding 9.6%. The rate was 12.5% and 4.3% for the CJSS and SSS

categories respectively. The only tertiary school that provided figures indicated that out of a total of 64 teachers 18 were unqualified (39%). It is very doubtful as to whether this is representative of the tertiary situation.

A school-wise analysis of this data the table above reveals that out of 74 Primary Schools that completed the questionnaire 41 schools (70%) indicated that they were using unqualified teachers. For CJSS it was 10 out of 11 (90.9%), Senior Secondary Schools 4 out of 4 (100%) and the only Tertiary School that submitted the questionnaire also indicated that it used unqualified teachers. A close examination of this table further reveals that the above notwithstanding, the number of unqualified teachers that are used ranges from 1 to 5. The only outlier is the tertiary category that has more than 16 unqualified teachers.

Policy implications that can be drawn from the above data is that the Ministry of Education needs seriously investigate whether these levels of unqualified teacher's rates do not have any adverse implications for the success of the TCB project. The question is whether the Interactive Learning model can be successfully used to address HIV/AIDS issues under these levels of unqualified teachers.

6.3.3 Interactive Learning

It is abundantly clear that interactive learning technique is the vehicle by which the TCB project seeks to achieve the objective of minimizing AIDS impact at school level. It stands to reason that as the project progresses there will be a need to establish the extent to which TCB project is known and embraced by schools as well as to assess the prevalence of the use of the Interactive Learning teaching tool in order to gauge whether the project is on course. It was in this light that the study collected data on Interactive learning through school heads. Below is a summary of the main features that emerged.

Regarding the existence of TCB teams information in the table below indicates that about 50% of the schools did not have the teams in place and a few did not even know what the question was all about. This outcome is however understandable since the program was still at its inception stage. It should be expected that after a year all schools will be able to answer this question in the affirmative.

Table 6.2 Clubs and Teams in Schools

	Yes	No	N/A	Total
Capacity Building Team	33 44.6%	37 50%	4 5.4%	74 100%
Have Exchange Visit Program.	20 27%	35 47.3	19 25.6%	74 100%
Have IL trained Teachers	35 47.3%	26 35.1%	13 17.6%	74 100%
Actually practice IL	36 48.6%	21 28.4%	17 23%	74 100%
Have IL proficient Teachers	27 36.5%	19 25.7%	28 37.8%	74 100
Practice Peer Education	49 66.2%	12 16.2%	13 17.6%	74 100%

Exchange programs broaden teachers' minds and expose them to new ideas, and as such, they are able to accept new and progressive ideas. Emerging from the above Table is the fact that not many schools participate in these programs. The implication of this for the TCB project is that a lot of work will have to be done in order to have teachers buy into this new idea.

The preparedness of school to implement the TCB project can be gauged by the number of schools with at least one teacher who is trained in Interactive Learning. While 47.3% claimed that they had at least one teacher trained, a significant proportion(17.6%) seemed not to know what Interactive learning is all about and this was at management level. It just might be possible that even the 35,1% that claimed not to have it did not know what this was all about. This assertion is actually corroborated by the fact that the percentage that claimed to have teachers trained is less than the percentage that has teachers actually using the teaching tool in practice (that is 47.3% against 48.6%) When the question on the proficient use of the tool was raised, the percentage of those who are not sure increases to 37.8%. It is tempting to conclude from these results that this teaching tool is not yet prevalent and widely used in Botswana. It seems only logical to suggest that concerted effort will have to be made to popularise this teaching tool if the TCB project is to succeed.

Learning from fellow colleagues can also increase the openness of teachers' minds and thereby making them more amenable to new ideas such as those espoused by the TCB project. It is gratifying to observe from the survey that as high as 66.2% of schools practice Peer Education.

Although they are armed with knowledge as well as being social entrepreneurs in as far as morality is concerned, teachers have not been spared by the HIV/AIDS scourge. Consequently, the school system has experienced high absenteeism and in some cases death. It therefore stands to reason the teachers are not only conduits through which the TCB will transfer information to students but they will also be beneficiaries. It is therefore expected that as the project progresses, some changes should be discernable for teachers. Baseline data on absenteeism and deaths had to be collected and it is given below. While the majority of school (25%) could not give the exact figures on absenteeism 20.3% reported that they had had absenteeism to the tune of up to two months and 27% for up to 1 month. Some even reported up to 3 months. The TCB project would like to monitor whether this picture will get worse or improve over time as the project progresses.

Table 6.3 Teacher Absenteeism Rates.

Range	Absenteeism in Man-days	% school reporting
1 – 30	20	27%
31 – 60	15	20.3%
61 – 90	6	8.2%
91 - 200	8	11%
200+	1	1.4%
N/A	25	33.8%
Total	74	100

The picture regarding teacher-deaths in schools is as captured in the table below. While Primary Schools have double the number of secondary school teachers as their deaths are 16 folds those of CJSS category. It is also clear from this table that female deaths in primary schools are significantly more than males' The TCB project might do well by targeting this group.

Table 6.4 Teacher Deaths in Schools

	Male	Female	Total
Primary	12	20	32
CJSS	1	1	2
SSS	3	1	4
Tertiary	-	-	-
Total	16	22	38

6.3.4 Student Specific Information

Student aspects that are of consequence to the TCB project are Sex Ratios Drop out rates and their reasons as well prevalence of death. Information on the existence of youth and HIV/AIDS clubs can also assist gauge the intensity of AIDS awareness campaigns at school level. Sex Ratio is important in that female students are more prone to specific risks than males when it comes to HIV/AIDS problems. Advance knowledge on which category dominates the student population can be of policy strategic importance. Regarding Drop out rates, it will be of policy significance to document the extent of drop out phenomenon and its dominant causes. For example, drop out due to pregnancy will be a good measure of the prevalence of unprotected sex. Findings on these three aspects are summarized below.

Table 6.5 Girl/boy ratios for different School Categories

School Category	Ratio
Primary	0.91
CJSS	1.10
Senior School	1.16
Tertiary	0.97

The above table indicates that for schools that were interviewed, there were more boys than girls at Primary School Level and scales were tilted for CJSS and SSS categories and for the only tertiary school that responded there were more boys than girls. To the extent that this data is thought to be representative of the global school situation, this set of data carries a very important message. Girls mature faster and if there are more girls than boys at both

CJSS and SSS levels, if they are to engage on sexual activities, this will most likely be with people older than them, thus leading to the sugar-daddy phenomenon. The TCB project should therefore target this aspect among other targets.

The figure for primary schools is a bit worrisome. Given that at the national level there are more females than males one would expect that female primary student are, at the very least, equal to males. One possible explanation for this figure is that some of the girls who are supposed to be at school are not at school. In the olden days this used to be the case due to parent's unwillingness to send girls to school. If this low figure portrays that behaviour, this then has adverse implications for AIDS awareness campaigns. The TCB project might want to probe this fact further.

Table 6.6 Drop out Rates for Different School Categories

	MALE	FEMALE	TOTAL
Primary	1.04	1.39	1.20
CJSS	1.64	2.08	1.87
Senior School	1.06	0.19	0.56
Tertiary	-	-	-

The above table reveals that drop-out rates are highest for CJSS followed by primary schools with the SSS category coming last. A closer analysis by gender reveals that CJSS girls have the highest drop-out rates followed by CJSS males with SSS males coming third. It is however consoling to observe on the table below that pregnancy is not the main cause of drop out rates for all groups including CJSS females. This notwithstanding, the table below reveals that pregnancy dropout occurs at all levels even at primary school level. This is one statistic that the TCB should target and monitor. Admittedly, absolute figures are low relative to the group size, but there is a clear message that unprotected sex occurs even at primary level. It is however, interesting to note that pregnancy is the sole cause of drop-out at SSS level.

The table shows that illness is the second most important for all school levels and it accounts for 30.3% SSS drop-outs. This is the second most important statistic that the TCB project should monitor. Social problems related are the most dominant cause for drop-out from

school. There are two possible explanations for this. One could be the common RADs problem where Basarwa children desert schools. Second it could be the manifestation of the HIV/AIDS problems at household level where children ability to attend school is negatively affected. However this table has very vital information that the TCB project will need to closely monitor.

Table 6.7: Total number of Drop Outs per School Category

	PRIMARY			CJSS			SENIOR		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Pregnancy	-	13 6.4%	13 3.5%	-	21 27.3%	21 15.9%	-	4 100%	4 12.1%
Illness	15 9.0%	32 15.8%	47 12.8%	3 5.5%	3 3.9	6 4.5	10 6.6%	-	10 30.3%
Social problems	138 83.1 %	139 68.8%	277 75.3%	52 94.5%	53 68.8%	105 79.5	19 65.5%	-	19 57.6%
Distance	13 7.8%	18 8.9%	31 8.4%	-	-	-	-		-
Total	166 100 %	202 100%	368 100%	55 100%	77 100%	132 100%	29 100%	4 100%	33 100%

On the question of the prevalence of death among school children a total of 57 deaths were reported with 47 of them occurring at primary school level 7 at SSS and 2 at CJSS. While these can not be attributed to HIV/AIDS this information will be used for baseline comparison in the future.

6.3.5 Youth and HIV/AIDS related clubs

The medium through which HIV/AIDS information can be accessed is through these youth clubs. How the TCB project will arouse interest of schools in these clubs can be gauged by looking at the establishment of these over time. Solidarity and coalition between the TCB project and these clubs might be one avenue that can be explored for addressing HIV/AIDS issues.

Twenty (27%) of also the schools that were interviewed claimed to have any HIV/AIDS clubs and 18 (22.8%) claimed to Scripture Union Clubs in and rather surprisingly only 4(5.4%) indicated that they had 4B clubs and similarly only 4 indicated PACT. The overall picture on this front is a very discouraging one as these are the channels through AIDS awareness campaigns are supposed to have taken root at school level. The TCB Project will have to target boosting interest of school in these clubs. Lacking of funding was cited to be the major cause of this problem.

6.3.6 Conclusion

This part of the study has established that unprotected sex does take place at school level even at Primary School level as indicated the pregnancy related drop out rates. However Dropouts are mainly caused by Social Related problems. For Teachers, the rate of absenteeism is significant and regarding the Interactive Learning system, school managers do not seem very conversant with this technique. Implication for high unqualified teachers rates for the success of the TCB project needs to be established.

6.4 Students' Knowledge and Perceptions of HIV/AIDS

6.4.1 Socio-Demographic Profile of Students

This section presents the socio-demographic profile of the students interviewed during the survey. A total of 5647 students were covered by the baseline survey and all the questionnaires were self-administered. Of these, 53% were female and 47% male. The largest proportion of the sample was composed of students aged 12 and 13 years, and these are primary school students. The minimum age was 9 years and the maximum age was 48. Most students are single (95.8%), 1.3% are married, 1.9% are cohabiting, 0.7% are separated and 0.3% are divorced.

The baseline shows that students' sexual orientation is varied the same way as of that of teachers (Section 6.5). Majority of the students identified the sexual orientation as heterosexuals (86.1%), while 2.2% identified themselves as homosexual, 3.9% identified themselves lesbian while 7.9% identified themselves as bisexual. Majority of those who are not heterosexual are mainly at SSS and tertiary institutions.

6.4.2 Knowledge about HIV/AIDS, Testing and Sources of Information

6.4. 2.1 Introduction

Botswana faces a very serious HIV/AIDS challenge, which threatens the achievement of Vision 2016 objective of having an HIV/AIDS free society by 2016. However, this challenge can be reduced if today's school children have full knowledge about HIV/AIDS. Students, who are well informed of AIDS issues, will be in a position to make safe choices, which will preserve themselves and the nation. In addition, today's students are going to be tomorrow's out-of-school youth, and therefore an aggressive HIV education in schools will help improve HIV awareness or lack of it among out-of-school youth.

From the field survey, students generally know about HIV/AIDS, how it can be transmitted and prevented. The level of awareness improves with the level of one's education. Those in lower levels of education, primary and junior secondary schools displays higher levels of ignorance about HIV/AIDS, in particular those in primary schools. The majority of students

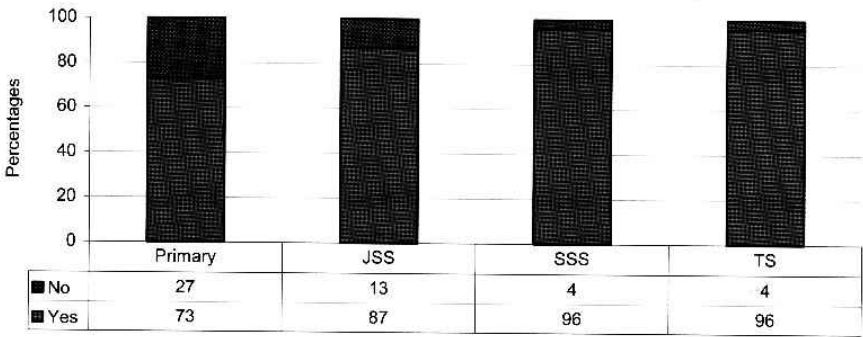
understand what the phrases like “unprotected sex” mean, though some concerning misperceptions do persist.

Students indicate that they are primarily receiving information about HIV/AIDS from the media and school, and that parents and family are playing a lesser role in educating them about these topics. The level of awareness about HIV/AIDS counseling and testing centres is very low at lower levels of education compared to higher levels of education.

6.4.3 Knowledge About HIV/AIDS

The level of aids awareness in schools improves with the level of education. More students in primary schools (27%) reported to not have ever heard of AIDS, compared to fewer in higher levels of education; Junior Secondary Schools (13%); Senior Secondary School (4%), and Tertiary Schools (4%) (see Figure 6.1 and the last column on Table 6.8).

Figure 6.1 Ever Heard of an Illness Called HIV/AIDS?



In all levels of education females heard about AIDS more than boys. In primary the percentages were 35% males and 38% females; JSS 40% males and 47% females; SSS 44% males and 52% females, and TS 38% males and 58% females. This is further reflected in Table 1, where even at regional level females tended to have heard about aids more than males did. In Table 1 we also find out that HIV/AIDS awareness vary by region. For both females and males the level of awareness is lower in rural areas compared to urban villages and urban areas. The level of awareness is highest in urban areas. Across education level, it is

also clear that students who are in urban areas are more informed or aware of HIV/AIDS compared to those in urban villages and rural areas. The Table further reveals high levels of awareness in Junior and senior secondary schools students, although males in junior secondary schools tended to show lower awareness levels relative to those of their counterparts.

Table 6.8 Have You Ever Heard About HIV/AIDS (%)

School	Region	Female		Males		Both Sexes	
		No	Yes	No	Yes	No	Yes
Primary	Urban	15	85	20	80	4	16
	Urban Villages	25	75	38	62	2	6
	Rural	30	70	28	72	21	51
	Total					27	73
JSS		Female		Males		No	Yes
	Urban	2	98	12	88	0	7
	Urban Villages	8	92	11	89	3	28
	Rural	14	86	20	80	10	52
SSS	Total					13	87
		Female		Males		No	Yes
	Urban	3	97	3	97	0	34
	Urban Villages	2	98	3	97	2	28
Total	Rural	6	94	6	94	2	34
	Total					4	96

However, the overall picture as depicted by the last column entitled both sexes shed some very interesting information. It reveals that the majority of students who participated in this survey were from rural areas, especially primary and junior secondary students. Thus, explaining the percentage figure that seems to counter the earlier conclusions that awareness levels are lower in rural villages compared to urban areas.

6.4.4 Knowledge About HIV/AIDS Prevention

From Figure 6.2 below the majority of students across education levels (75% in primary; 85% in JSS; 99% in SSS, and 97% in TS) agreed with the statement “is there anything one can do to avoid getting HIV”. Thus, suggesting higher levels of HIV/AIDS prevention awareness among students, especially at higher levels of education.

Figure 6.2 Is There Anything One Can Do to Avoid HIV/AIDS



However, when you break the “Yes” answers according to gender, the same picture as above emerges; more females than males know that there is something that one can do to avoid getting HIV (see Table 6.9). In primary of the 75% who said “yes”, 40% were female and 35% males; in JSS 45% females compared to 40% males; SSS 54% females compared to 45% males, and lastly in tertiary 55% females and 42% males. However, the high awareness among females compared to males do not tally with the statistical evidence from previous studies, which shows that more females than males are infected or are living with HIV/AIDS.

Table 6.9 Things One What Can Do Avoid HIV/AIDS (Percentages)

School	Region	Female		Males		Both Sexes	
		No	Yes	No	Yes	No	Yes
Primary	Urban	12	88	17	83	3	17
	Urban Villages	33	67	40	60	3	5
	Rural	25	75	27	73	19	53
Total						25	75
JSS	Urban	Female		Males		No	Yes
		9	92	26	74	2	7
	Urban Villages	7	94	9	91	2	29
	Rural	19	81	18	82	11	49
Total						15	85
SSS	Urban	Female		Males		No	Yes
		1	99	2	98	0	20
	Urban Villages	0	100	3	97	1	31
	Rural	1	99	2	98	0	48
Total						1	99

Figure 6.3 to 6.6 shows that a large percentage of students per education level responded by ticking the correct factors that can prevent a person from getting the virus that causes AIDS. Except for primary school students, abstaining from sex ranks as the number one thing that one had to do to avoid getting the virus that causes AIDS. Ranking second and selected by over 70% of students per education level is using condoms. In third and fourth place are avoiding “sharing razor blades” and “having sex with many partners”, which were selected by just under 40% in primary and JSS and over 40% in SSS and TS respectively. Thus suggesting that over 60% of primary and junior secondary students do not believe that having one partner can help reduce the spread of HIV. In addition, a fewer percentage of students still have misconceptions about the spread of HIV, as some gave unreasonable answers, such as avoid injections, kissing and mosquito bites, a large proportion of which were in primary schools. Moreover, 75% of primary and 80% of JSS students surveyed do not think that having sex with prostitutes is one way one can avoid the AIDS virus. This further confirms that the level of awareness about HIV/AIDS remains lower in primary schools, calling for a more aggressive awareness campaign about AIDS in these schools.

6.4.4.1 Indicator for Knowledge of HIV Transmission for Students

To assess the overall awareness of ways of preventing HIV among students, composite indicators (for all questions) and individual question indicators were developed by dividing all students who both correctly identified ways of preventing the sexual transmission of HIV and those who rejected major misconceptions about HIV transmission, by the number of students who gave answers. Responses to three survey questions are used to construct the indicators for students, and these are: 1) can the risk of HIV transmission be reduced by having sex with only one faithful partner; 2) can the risk of HIV transmission be reduced by using condoms, and 3) can a person get HIV from mosquito bites. Indicators are percentages of students disaggregated into age groups and education level, and have been both calculated for individual questions and composite indicators have been computed by aggregating all questions.

From Table 6.10, the composite indicators show that standard five pupils in primary schools are more knowledgeable about HIV transmission and prevention compared to those in standard 6 and 7. In other words, the level of awareness declines from standard 5 to 6 and then to standard 7. This could suggest that a non-structured and consisted form of sex education lessons may be taught in primary schools, and the ability to communicate the content of the lessons varying by the teacher's abilities to teach the very sensitive subject. The low level of individual indicators for question 1 suggest that the majority of primary students do not believe that the risk of HIV transmission can be reduced by having sex with only one faithful partner. This is in contrast to the fact that 62% and 58% of standard 5 and 6 believe that the risk of HIV transmission can be reduced by using condoms. Over 60% of all primary school students do not believe that a person can get HIV from mosquito bites.

Table 6.10 Primary School Indicators by Standard of Education

Standards	Q 1 Indicator (%)	Q 2 Indicator (%)	Q 3 Indicator (%)	Composite indicator
Std 5	34.5	62.6	61.7	24.9
Std 6	29.3	58.7	61.0	19.3
Std 7	25.8	51.7	60.2	18.8
TOTAL	28.7	56.0	60.8	20.3

Note: Q1, Q2 and Q3 in table refer to question 1, question 2 and question 3.

From Table 6.11 the composite indicators show that in Junior Secondary schools the level of awareness about HIV transmission and prevention improves with education class level. That is, those in Form 1 are less informed compared to those in Form 2 and 3, in that order. Overall the composite indicators are very low, thus suggesting that correct knowledge of modes HIV transmission and prevention are low among students in junior secondary schools, though lightly better than those for primary students. As for the individual question indicators, responses to question 1, as in primary students shows that the majority of Junior Secondary students do not believe that the risk of HIV transmission can be reduced by having sex with only one faithful partner. The indicators to question 2 and 3 shows that more students at JSS compared to those in primary believe that the risk of HIV transmission can be reduced by using condoms and they also do not believe that a person can get HIV from mosquito bites. However the composite indicator for standard sevens is greater than that of Form 1 by 0.7 points.

Table 6.11 Junior Secondary Schools indicators by class

Forms	Q 1 Indicator (%)	Q 2 Indicator (%)	Q 3 Indicator (%)	Composite indicator
Form 1	22.5	64.4	75.6	18.1
Form 2	27.8	63.0	79.2	21.9
Form 3	30.6	61.9	85.5	25.6
TOTAL	28.5	62.6	81.8	23.2

Note: Q1, Q2 and Q3 in table refer to question 1, question 2 and question 3.

From Table 6.12 the composite indicators show that in Senior Secondary Schools the level of awareness about HIV transmission and prevention improves with education class level just as in junior secondary schools. Both Form 4s and Form 5s have higher composite indicators compared to primary and junior secondary schools. Overall the senior secondary indicators are very low, but relatively higher than those for primary and junior secondary schools. In addition the individual question indicators are higher for both questions compared to those for primary and junior secondary schools. Thus, suggesting that correct knowledge of modes HIV transmission and prevention is higher among students in senior secondary schools.

Table 6.12 Senior Secondary Schools Indicators by Form

Forms	Q 1 Indicator (%)	Q 2 Indicator (%)	Q 3 Indicator (%)	Composite indicator
Form 4	34.0	72.2	92.0	29.6
Form 5	34.0	72.1	92.1	29.8
TOTAL	34.0	72.2	92.1	29.7

Note: Q1, Q2 and Q3 in table refer to question 1, question 2 and question 3.

Table 6.13 shows indicators shown by student age groups. The indicators reveal a similar pattern as above, which suggests that the level of awareness about HIV transmission and prevention improves with age. With older students in secondary schools (aged 17-18) and tertiary school (above 18) being more aware compared to those in primary (aged 9-13) and junior secondary (aged 14-16) schools.

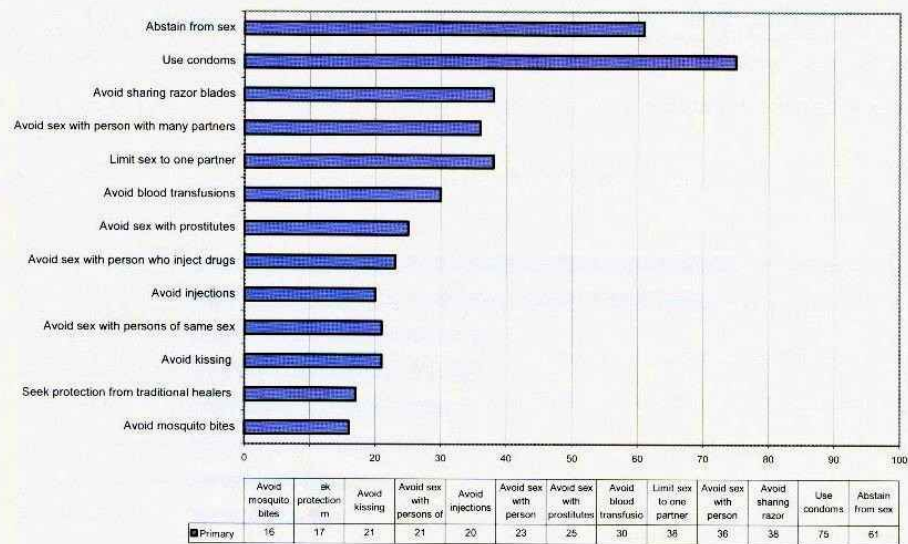
Table 6.13 Student Group Age Indicators

Age Groups	Q1 indicator (%)	Q2 indicator (%)	Q3 Indicator (%)	Composite indicator
9 – 13	29.3	59.1	63.9	21.0
14 - 16	28.9	59.5	75.9	22.7
17 – 18	35.8	72.8	89.6	30.7
Above 18	32.9	70.5	90.4	29.3
TOTAL	31.0	63.4	76.1	24.5

Note: Q1, Q2 and Q3 in table refer to question 1, question 2 and question 3.

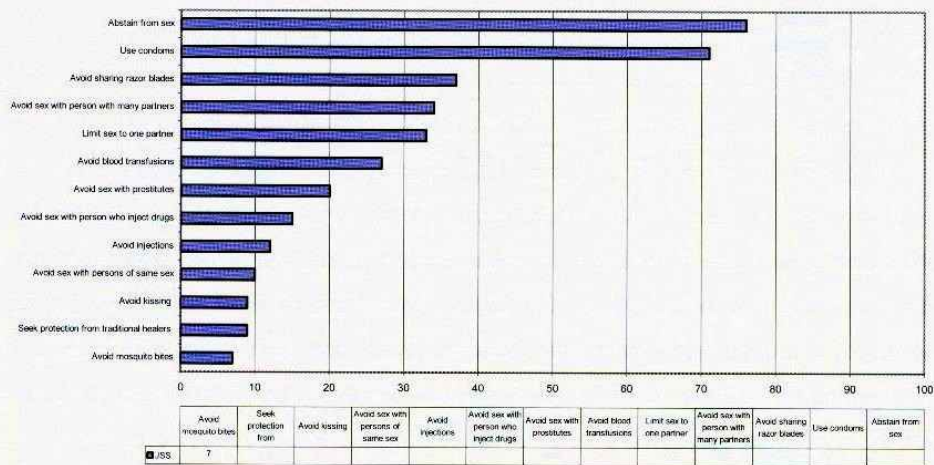
Overall, this suggests that the level of awareness about AIDS among those who have heard about the disease is higher among those with higher education and older in age. However, a large number of students do not believe that the risk of HIV transmission can be reduced by having sex with only one faithful partner, and almost 40% of primary students believe that a person can get HIV from mosquito bites. These are serious misconceptions that need to be addressed, as they weaken the resolve and motivation to adopt safe sexual behaviour.

Figure 6.3 Primary: What One Can Do to Avoid HIV/AIDS (Percentage)



For primary schools, abstaining from sex and using condoms is ranked very high, with 61% and 75% respectively. The graph shows that those who believe that consulting traditional doctors or avoiding mosquito bites are in the minority, with only 17% and 16% respectively (Figure 6.3).

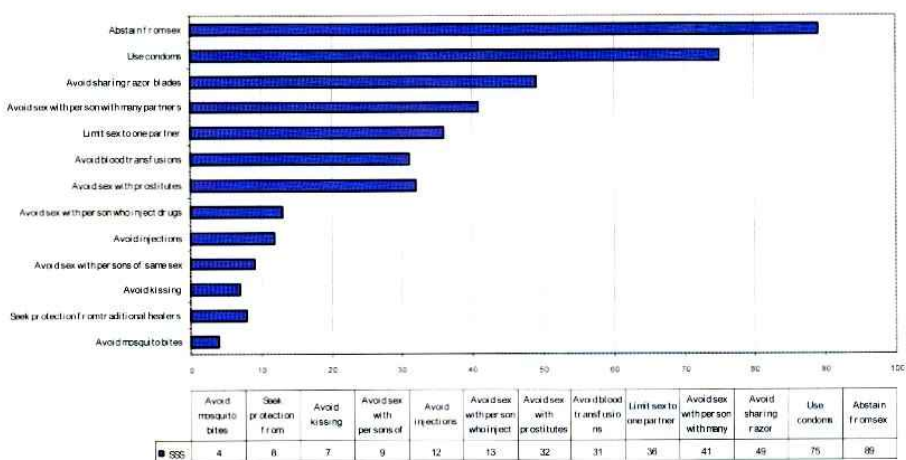
Figure 6.4 CJSS: What One Can Do to Avoid HIV/AIDS



A similar pattern is registered with community junior secondary schools with slightly higher percentages for abstaining from sex 76% and using condoms 71% (Figure 6.4) Misconceptions seems to wear off as one goes up the education ladder as depicted by lower percentages for consulting a traditional doctor 9% and avoiding mosquito bites 7% (Figure 6.4).

Senior secondary schools registered a small percentage of those who have misconceptions about the transmission of HIV/AIDS. Figure 6.5 above shows that the percentage of those who indicated that consulting traditional doctors, avoiding mosquito bites, avoiding injections and avoiding having sex with persons of same sex is less than 10%. Knowledge about HIV/AIDS transmissions seems to increase with the level of education (Figure 6.5)

Figure 6.5 SSS: What One Can Do to Avoid HIV/AIDS (Percentage)



A slight increase in percentage with respect to consulting traditional doctors, avoiding mosquito bites, avoiding injections and avoiding having sex with persons of same sex is registered for tertiary institutions. More than 10% believe that consulting a traditional doctor will help avoid getting HIV (Figure 6.6). The same applies to having sex with a person of same sex, tertiary institutions registered 22% as compared to only 9% of senior secondary schools. The misconception levels are much higher than junior secondary schools and more

or less similar to that of primary schools. This may be attributable to the fact that students in some tertiary institutions do not have senior secondary education, and hence their level of knowledge about HIV/AIDS may be similar to that of junior secondary students or less.

Figure.6.6 TS: What One Can Do to Avoid HIV/AIDS (Percentage)

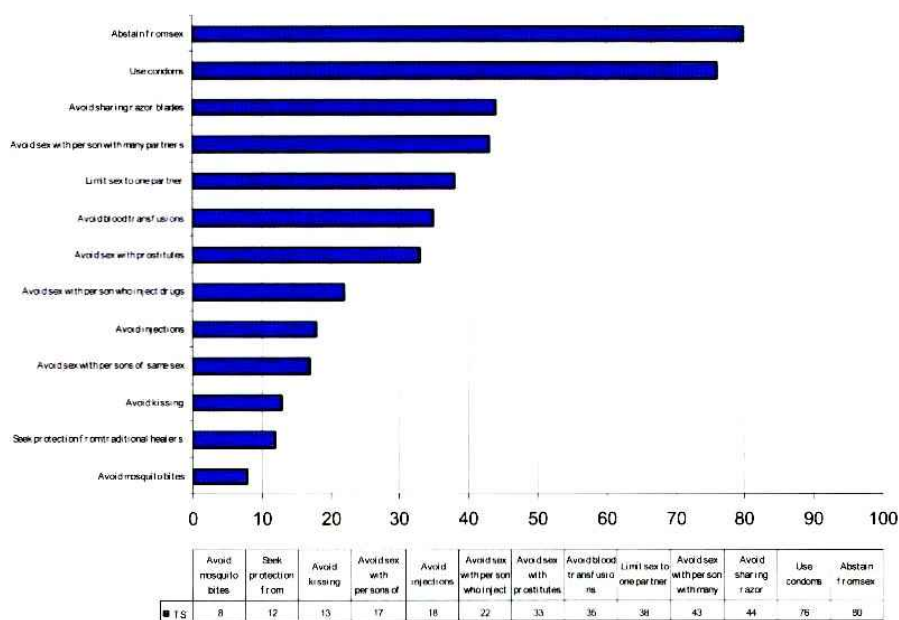


Table 6.11 below analyze further by gender and region, the two most popularly selected and correct factors, which could avoid one from getting AIDS, and two selected misperceptions about AIDS as captured in the above figures. The table shows that in primary schools, regardless of gender and region condom use attracted the top vote over abstinence in contrast to other levels of education, which chose abstinence. In addition misperceptions about HIV transmission are quite strong among primary students, in particular, those from urban villages and rural areas. This further underscores the point that lack of adequate knowledge about HIV transmission and or prevention is quite widespread in rural areas. It is in rural areas that one finds myth about HIV/AIDS very strong.

Table 6.14 Things One Can Do to Avoid HIV/AIDS (Percentages)

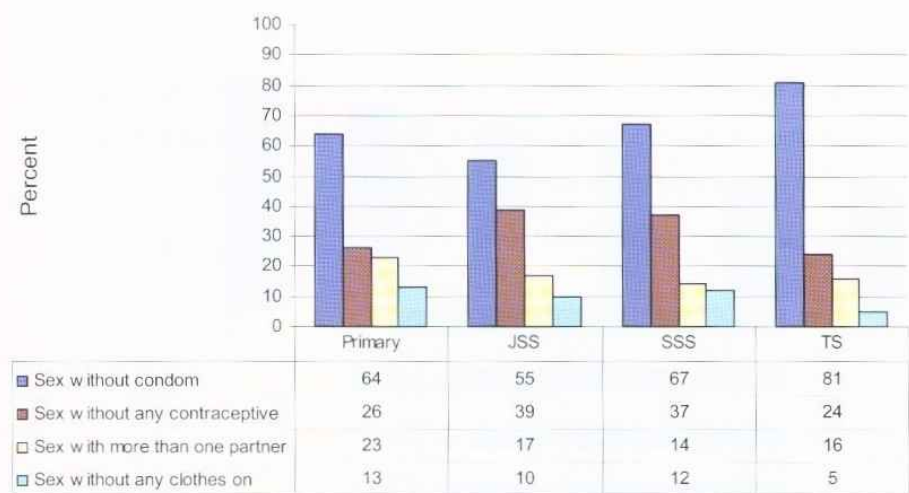
School	Region	Female			
		Abstain	Use condom	Avoid injections	Avoid Mosquito bites
Primary	Urban	67	76	14	9
	Urban Villages	55	76	26	17
	Rural	62	74	21	17
JSS	Urban	90	66	13	3
	Urban Villages	82	68	10	5
	Rural	76	74	13	5
SSS	Urban	92	73	16	5
	Urban Villages	82	73	9	3
	Rural	91	76	9	3
		Males			
		Abstain	Use condom	Avoid injections	Avoid Mosquito bites
Primary	Urban	64	76	11	11
	Urban Villages	43	76	24	17
	Rural	58	76	21	18
JSS	Urban	74	77	13	7
	Urban Villages	76	69	9	6
	Rural	79	71	14	9
SSS	Urban	91	81	18	7
	Urban Villages	84	79	8	4
	Rural	71	71	8	4

The overall picture that emerges from the above figures and Table 6.11 is that lack of adequate knowledge on the mode of transmission/prevention of HIV/AIDS still persists given misconceptions registered across all education levels. It can also be argued that students share the same misconceptions about HIV/AIDS with the general public, as some of the misconceptions, e.g., HIV/AIDS being caused by mosquito bites and kissing are also held by the general public.

6.4.4.1 Knowledge About Unprotected Sex

Most students are familiar with the phrase “unprotected sex” but have varying levels of understanding about what the term means (Figure 6.7). While a majority of students across all education levels indicate that unprotected sex refers to sex without a condom, sex without any contraception is another definition offered. Sex with more than one partner and sex with no clothes on were the third and fourth option across all education levels, again suggesting the presence of misconceptions.

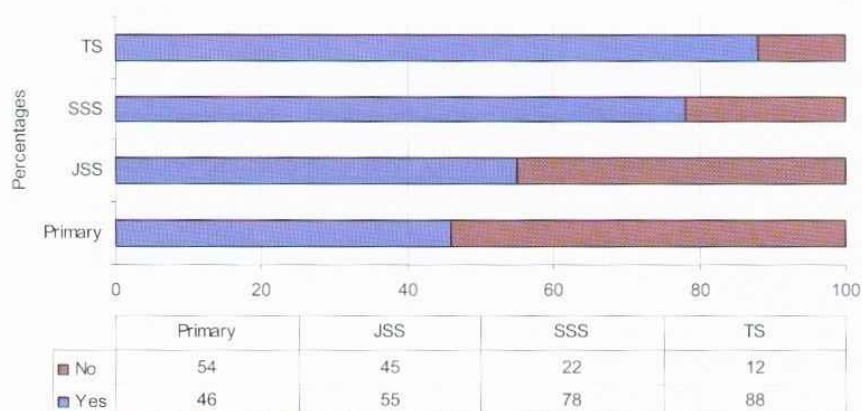
Figure 6.7 What Does Unprotected Sex Mean?



6.4.5 Knowledge About HIV Testing

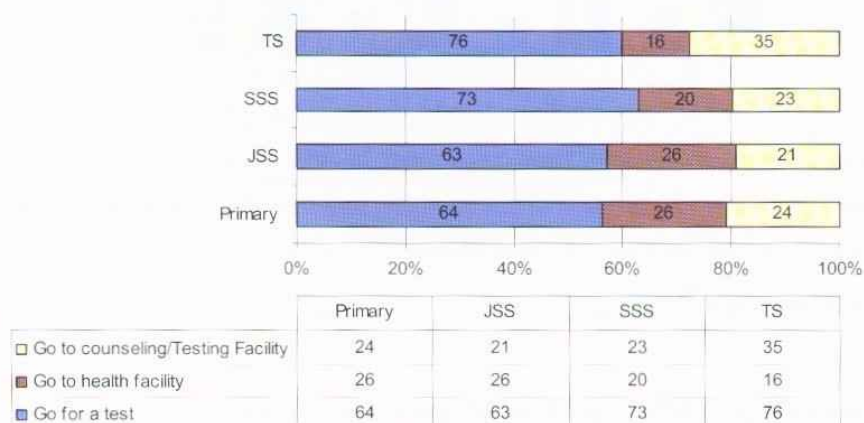
The level of awareness about HIV/AIDS counseling and testing centres is very low at lower levels of education compared to higher levels of education. Fewer than half of primary students knew about HIV/AIDS counseling and testing centres, compared to 88% in tertiary schools (see Figure 6.8 below).

Figure 6.8 Having Heard of HIV/AIDS counseling and Testing Centres



But the majority of students stated correctly that one can find out their HIV status by going for a test. The remaining students observed that a health facility and combining counseling and testing for HIV/AIDS at any testing facility as another option (Figure 6.9).

Figure 6.9 How One Can Find Out if She/He has AIDS

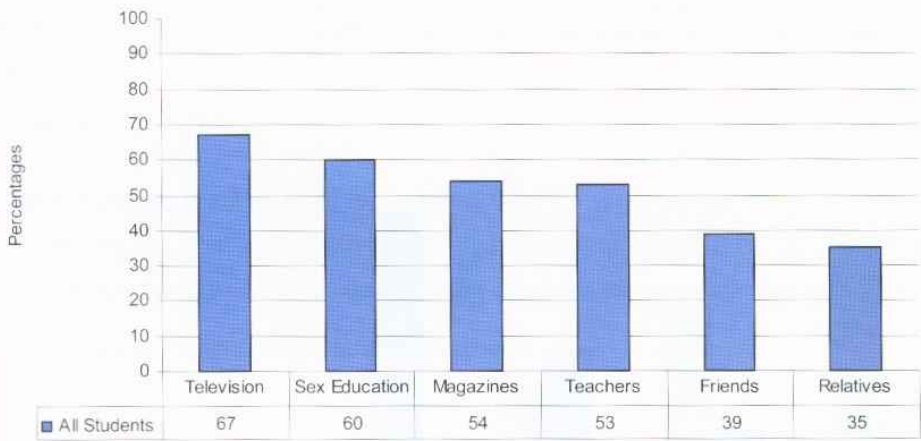


On a follow up question that wanted to establish where they will prefer going for an HIV test students indicated their choice as follows: Testing Centres (primary 61%; JSS 57%; SSS 73%; and TS 77%. Their second choice was hospitals at under 40% and lastly health clinics in the 20%.

6.4.6 Sources of Information About AIDS

Students are most likely to say that media (television and magazines), sex education lessons, teachers, or friends provide them with information about HIV/AIDS (Figure 10). A majority of student say they get information about AIDS from television (67%) or magazines (54%). Teachers are also named as a source of information about AIDS by 53% of students. Less than half name friends (39%) and relatives (35%) as a source of information about AIDS.

Figure 6.10 Source of information on AIDS



It appears students get a lot of information about AIDS from television than any other sources. This calls for a concerted effort to increase the current television viewership among students from its current level of about six in ten (67%).

6.4.7 Behaviour and Attitude About HIV/AIDS

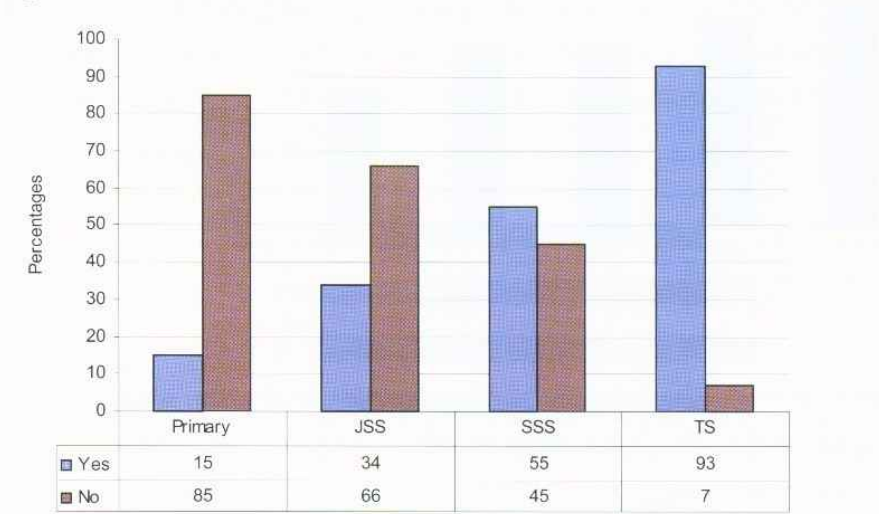
It is clear from the above section that students are aware of HIV/AIDS. Whether, students use such knowledge to adopt sexual behaviour patterns that will prevent or minimise their chances of being infected with HIV, is another issue. Educating students about HIV can improve their self-confidence and ability to make informed choices, such as postponing sex until they are mature enough to protect themselves from HIV, other sexually transmitted diseases and unwanted pregnancies. This section analyzes the extent to which knowledge

about HIV/AIDS influence behaviour patterns, beliefs and attitudes of school youth in relation to HIV/AIDS.

6.4.7.1 Ever Had Sexual Contact

Figure 6.11 shows that majority of student in lower education levels have never had sex before (85% in primary schools, and 66% in JSS and just below half 45% in SSS). This suggests that there is still hope of encouraging students in lower education levels to delay sexual activity through preaching the values of abstinence, and the dangers of being infected with HIV/AIDS. Of those who had sex before only 15% are at primary schools, 34% for junior secondary schools and 55% for those at senior secondary schools.

Figure 6.11 Ever Had Sex Before?



The age at first sex appears to have fallen over time assuming the reported mean age at first sex for tertiary students in row 6 of Table 6.12 as a benchmark. From the table, the mean age for tertiary student at first sex was 17 years, while the age at first sex for senior secondary schools is 15 years, JSS 14 years and primary schools 13 years. This suggests that the majority of today’s tertiary students started having sex while there were at senior secondary school level, and at an age that, it can be, assumed that they understood matters of sex a little bit better. Yet in recent years, based on primary, JSS and secondary students’ statistics the age at first sex had declined to fall in the range 11-15 years, as reflected by significant

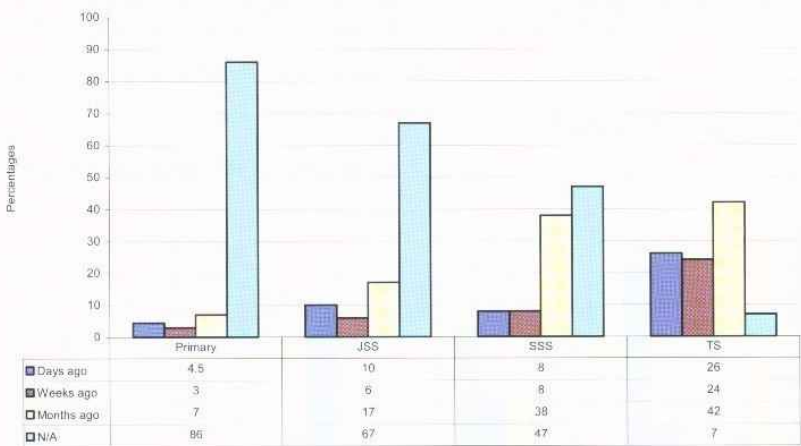
numbers of students at these levels who are engaging in sexual activity. However, majority of students appear not to have started engaging in sexual activities, as reported above.

Table 6.15: Percentage age at first sex for those who have had sex.

	School Categories				
Age at first sex	Primary	CJSS	SSS	Tertiary	Overall
6 to 10	1.5	1.4	1.2	2.0	4.8
11 to 15	10.3	20.2	16.0	11.2	48.2
16 or Above	3.2	12.4	31.8	33.0	47.0
Mean Age	13	14	15	17	15
Median Age	13	14	16	17	15
Modal Age	12	15	17	17	15

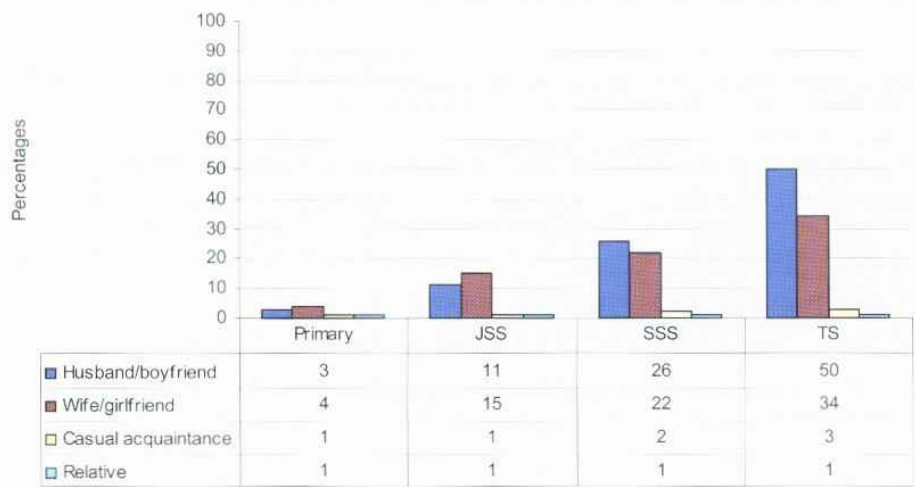
When students were asked about the last time they had sexual intercourse they responded in ways that suggests that sexual activity is more prevalent in higher levels of education (senior secondary and tertiary education, than in lower education levels (primary and JSS).

Figure 6.12 Last Time You Had Sexual Intercourse



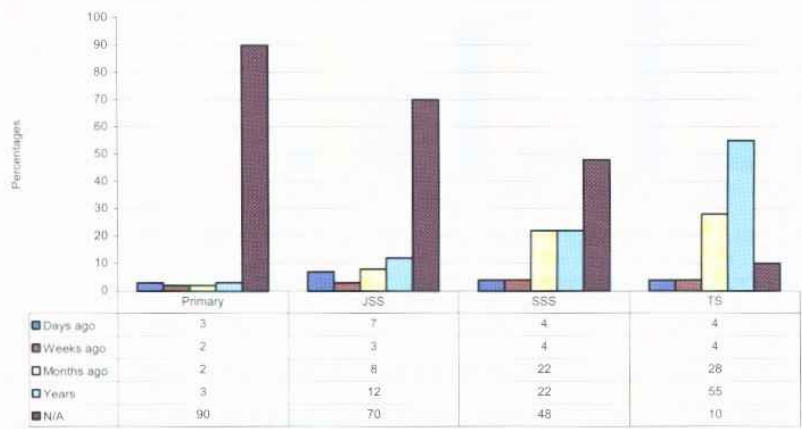
The majority of students indicated that they last had sex with their boyfriends, girlfriends, and those in tertiary institution with their husbands, wives, boyfriends and girlfriends (Figure 6.13). Thus suggesting that student have sex, and do it with their immediate sexual partners.

Figure 6.13 Relationship to the Person You Last Had Sex With



A few of those in lower levels of education, who had sex, did it with people they had known for a month or less. In senior secondary schools and tertiary institutions a lot of students who had sex did it with people they had known for a month or longer. That could suggest that the exchange rate of partners could be more prevalent among sexual active primary and junior secondary school students, and that in higher levels of education relationships tend to last longer.

Figure 6.14 Length of Relationship With Sexual Partner



Among primary students who are sexual active, the majority did not agree to have sex (see figure 6.15). A significant number of junior secondary schools students also did not agree to sex. Thus suggesting that students in lower levels of education are in most cases forced to have sex, and under such circumstances the most likely scenario is that they had no power to negotiate for safe sex. In other levels of education most students agreed to have sex, also suggesting that mature students have freedom to make independent choices about sex.

Figure 6.15 Did You Agree to Have Sex

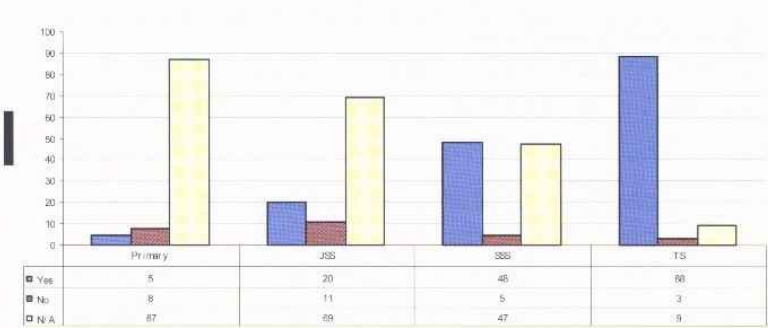
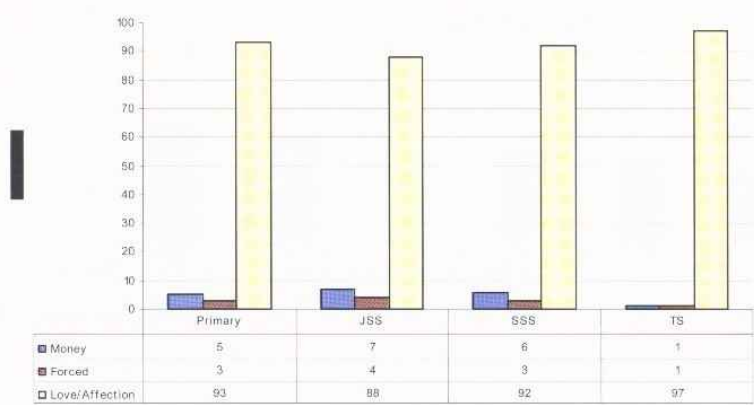


Figure 6.16 shows that a few students who engage in sexual activities did it for money. A much smaller percentage indicated that they were forced into having sex. The rest of the students did it for affection and love.

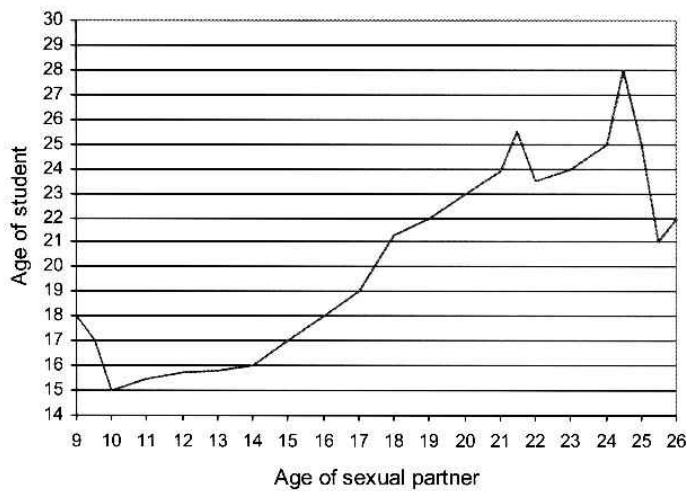
Figure 6.16 Reasons for Having Sex



6.4.8 Age Differential in Sex Partners

There is a general belief that the intergenerational sex perpetuates the spread of HIV. However, the results of the baseline study show at the ages, there seems to be a lot of intra-generational sex among students (Figure 6.16a). The age of a student has a direct relationship with the age of a sexual partner between ages 9 to 25 years. Beyond 25 years, there is oscillation in age of student and sex partner.

Figure 6.16a Age of Student and Sexual Partner



However, this fluctuation is smooth compared t that of teachers, whereby the age difference between sexual partners could be as large as 25 years. These results show that students have sex with fellow students. However, these results should be interpreted with caution given the limited geographic coverage. The age of partner variable was introduced late in the field work, therefore 50% of students especially in urban areas did indicate the age of the sexual

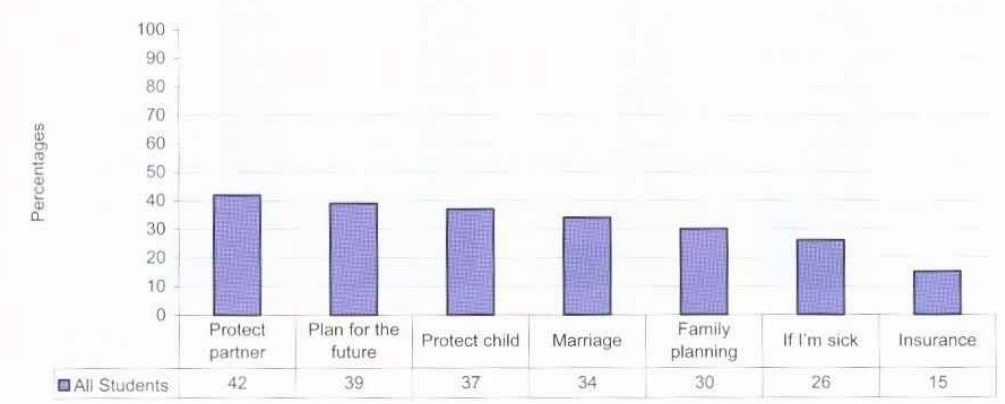
partner. However, Figure 6.16 above also shows that a large percentage of students had sex for love and affection, and a small percentage had sex for money, implying without motive for money, students engage in intra-generational sex.

6.4.9 Attitudes to Testing for HIV

Many students indicated that they have never tested or checked their HIV status. Yet, knowing one’s HIV status is an important tool for preventing HIV. A negative test result offers a key opportunity to reinforce the importance of safety and risk-reduction behaviours. Students who test HIV positive must know that they will receive referrals for care and opportunities to talk to knowledgeable people who can help them understand what their HIV status means and responsibilities they have to themselves and others as a result. Female students who are pregnant and test HIV positive must know that they will be offered special care to safeguard their own health and minimize the risk of passing the virus to their baby.

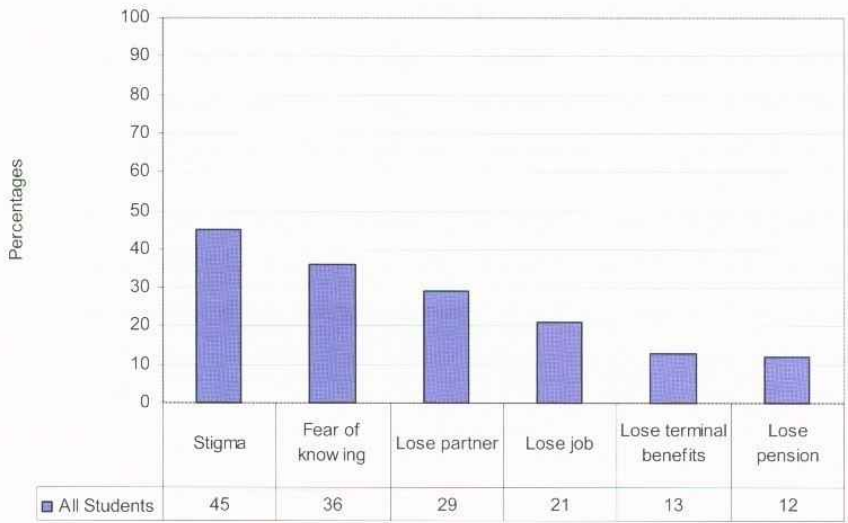
From the survey, and listed in their order of importance students will test for HIV/AIDS because they want to: protect their partner from infection; plan for the future with some level of certainty; protect an unborn child; marriage; family planning; because one is sick, and in seeking insurance cover (Figure 6.17).

Figure 6.17 Reasons for Getting an HIV/AIDS Test



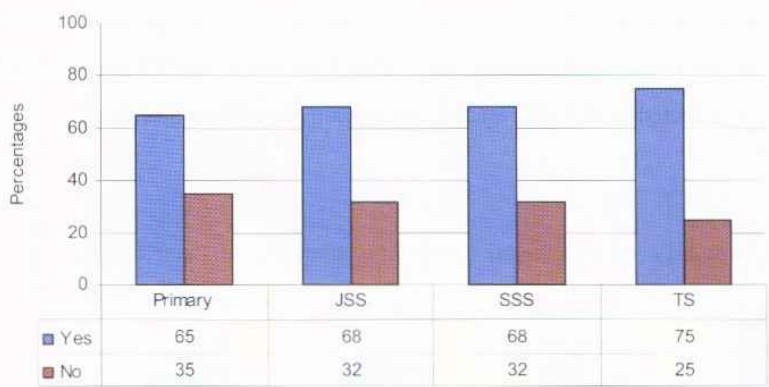
However, the fear of stigma and deep-rooted discrimination makes students less likely to adopt preventative strategies such as seeking testing for HIV and disclosing their HIV status to sexual partners. From the survey, a lot of students across all education levels will not be willing to go for an HIV test because of stigma and fear of knowing. In addition those in tertiary institutions will fear losing partner, losing ones job and terminal benefits as well as pension (Figure 6.18). This calls for concerted efforts to break the stigma and eliminate the shame associated with HIV/AIDS.

Figure 6.18 Reasons for not Testing for HIV



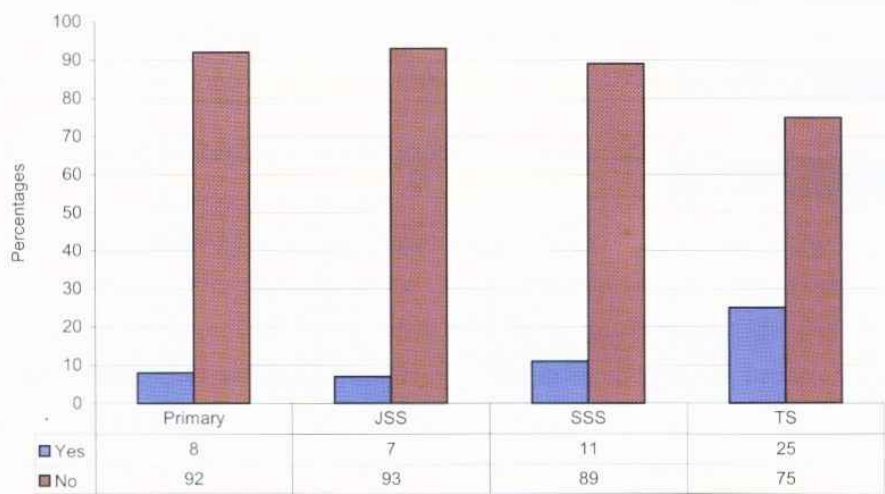
However, most students indicated that they will be able to talk to their partner or parents before having an HIV test. But a significant percentage of those in lower education levels will be less likely to talk to their partner or parents before having an HIV test (Figure 6.19).

Figure 6.19 Talking to Parents Before Testing for HIV



In a follow up question students indicated in a similar pattern as in figure 9 that they would tell their parents or partner the results of their HIV test.

Figure 6.20 Ever Been Tested for HIV in the last 12 months?

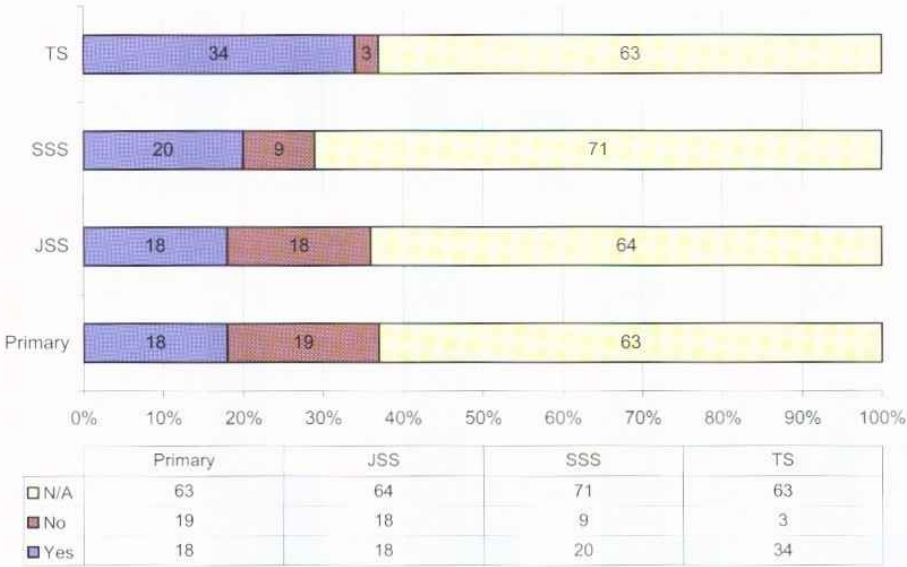


Overall the majority of students have never tested for HIV/AIDS. The percentages are high among those in lower education levels compared to those students in tertiary schools. The relatively high exchange rate of partners among students, and their ignorance of their HIV

status leave them very vulnerable to HIV. A study by UNICEF, UNAIDS and WHO in 2002, found out that two thirds of young people in their last year of primary school in Botswana thought they could tell if someone was infected with HIV by looking at them. At secondary school, a fifth of the students were found to still believe they could screen out risky partners by looks alone. This misinformation is especially dangerous in a country where one in three of their potential sex partners is infected with HIV, and could explain why the majority of students have not tested for HIV.

Among those who have tested for HIV, few received counseling, majority of them are in tertiary institution (34%). Only 18% of students at primary and junior secondary schools received counseling before testing for HIV (Figure 6.21).

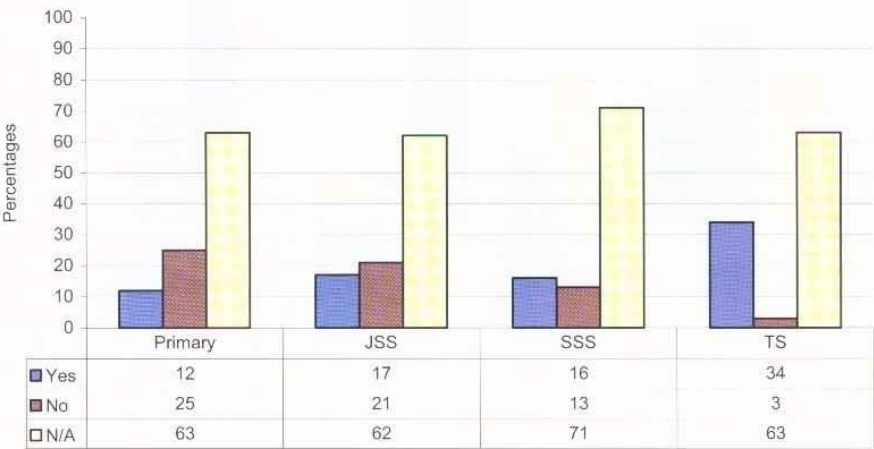
Figure 6.21 Any Counselling Before Testing?



The not applicable case is for those who did not test for HIV/AIDS.

Figure 6.22 shows similar trends, which suggest that fewer students surveyed received their HIV status results. A follow up question indicates that those who tested did not receive any counselling after getting their results.

Figure 6.22 Received Any Counseling After Testing for HIV?



Students indicated that the risk of becoming infected with HIV is high during unprotected intercourse. The survey results show that though students have general understanding about benefits of using condoms, however, many believe that it reduces sexual pleasure. Because of this, many risk being infected with STDs including HIV/AIDS.

6.4.10 Condom Use Among Students

Young people are less likely to use condoms at first sex, even when they do have information because they lack skills to negotiate for a condom use, or are too embarrassed to talk with their partner about sex. Still others, riding high on the misconception that they could tell if one has AIDS by just looking at them, may engage in unprotected sex because they perceive their individual risk as low. From the survey, condom usage was very minimal at first sex, and lowest among primary and junior secondary school students. Condom usage at first sex by senior secondary and tertiary students is quite high (Figure 6.23).

Figure 6.23 Condom Use at First Sex

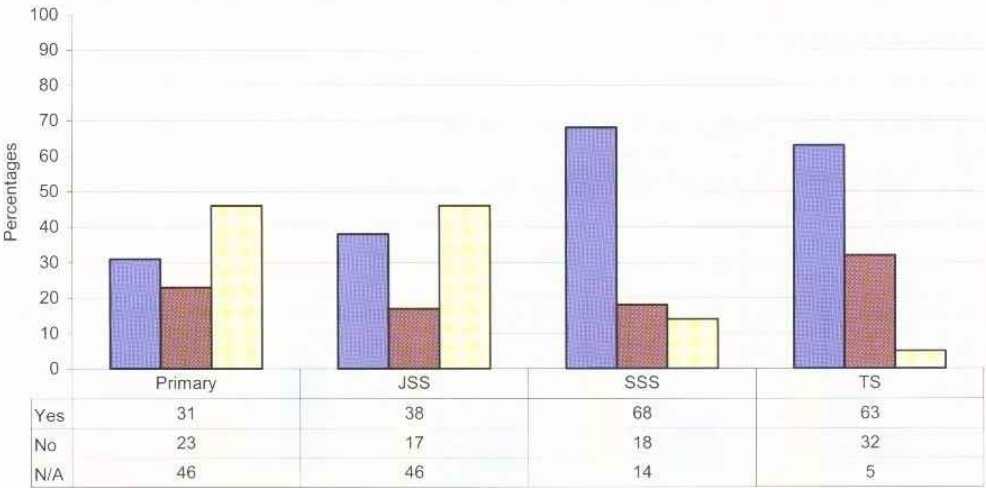
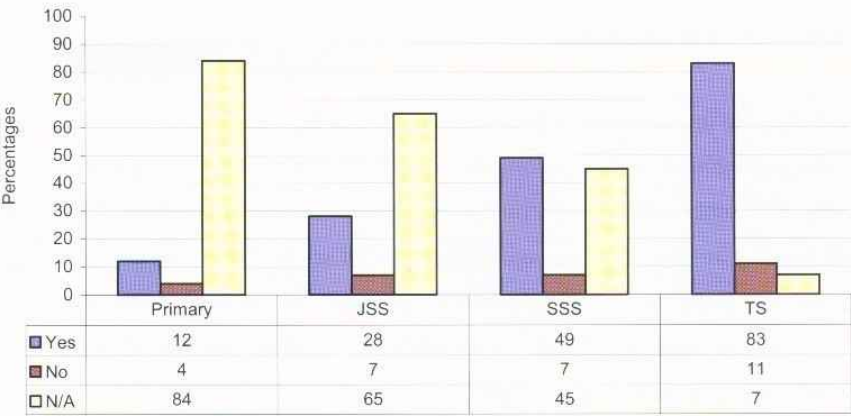


Figure 6.24 below, also shows a similar trend as Figure 6.27 above. Majority of students indicated that the last time they had sex they used condoms. The level of usage was again higher in high levels of education compared to lower levels (Figure 6.24).

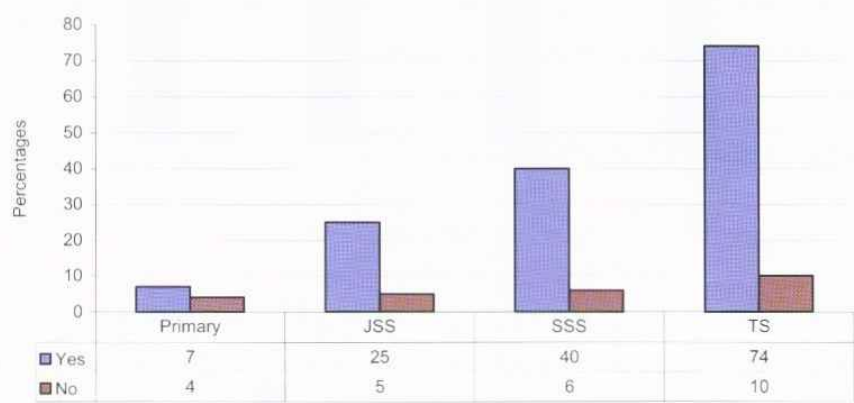
Figure 6.24 Condom Use at last Sex



However, many students indicated that they used condoms when they cheated on their partners. Only 4% of primary; 5% JSS; 6% SSS, and 10% tertiary students did not use

condoms when they cheated on their partners. However, the majority of those who cheated did use condoms (Figure 6.25).

Figure 6.25 Did You Use a Condom When Cheating



Preventing sexually transmitted diseases, HIV and pregnancy are the top main reasons students who engage in sex gave for using condoms. The other factors such as not trusting one’s partner, partner having other sexual partners, and partner insisting on using condoms rated least (Figure 6.26).

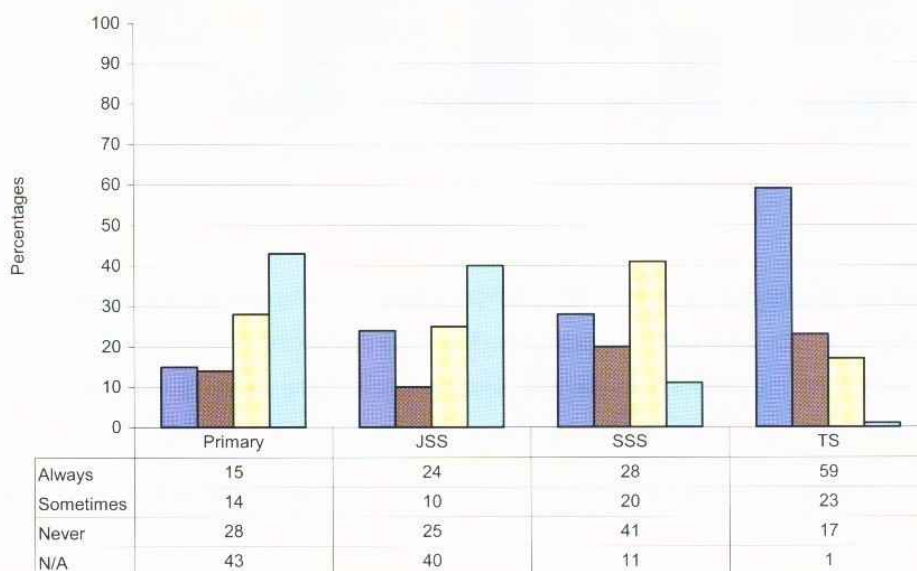
Figure 6.26 Main Reasons for Using Condoms



Figure 6.27 reveals that among those students who have sex, only a few in lower levels of education always and sometimes resist having sex without a condom. Almost half of students in each of the lower levels of education never resist having sex without a condom.

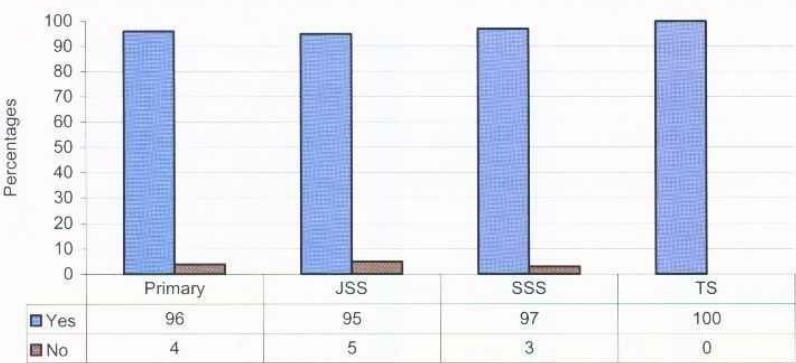
This confirms that many students lack the skills to negotiate for condom use during sex. The level of resistance is higher at tertiary level, thus suggesting that mature students possess skills to negotiate for condom use during sex. This is indicative of a lot of students being exposed to the dangers of being infected with HIV or falling pregnant. This calls for more aggressive information aimed at empowering students and youth in general on skills to negotiate for safe sex, especially targeting lower levels of education.

Figure 6.27 Do You Ever Resist Sex Without a Condom



However, almost all students knew of a place where one can get condoms (Figure 6.28). All students at tertiary institutions knew of a place where they can get condoms. This means that lack of use of condoms is not directly correlated to availability but rather to lack of skills and encouragement for the case of younger students.

Figure 6.28 Do You Know a Place Where One Can Get Condoms



For most students, hospitals, family planning clinics and government health centres are the main sources of condoms, followed by private hospitals and shops, where condoms are not supplied free. These are followed by pharmacy and, mobile clinics, with relatives and friends also playing an important role of supplying condoms. A few mentioned churches among the places where one can get condoms.

Figure 6.29 Places Where One Can Get Condoms

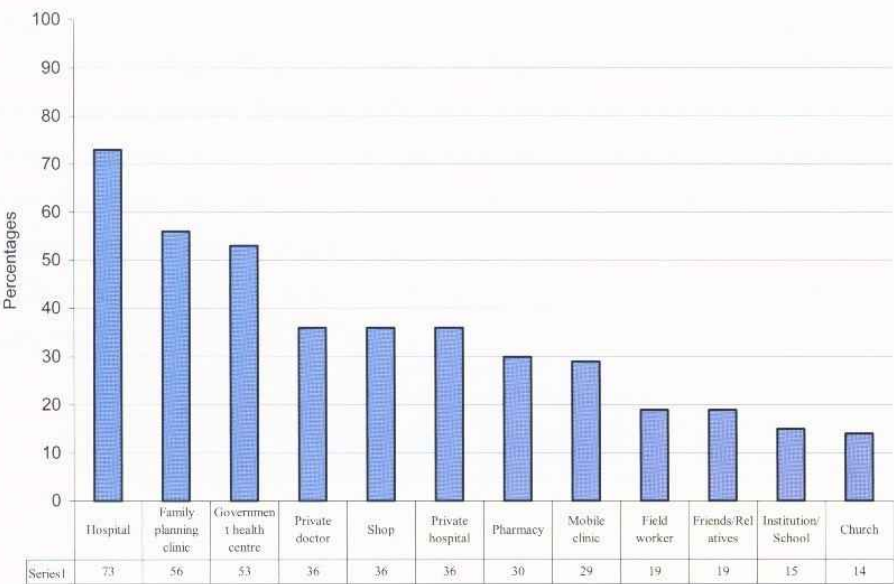
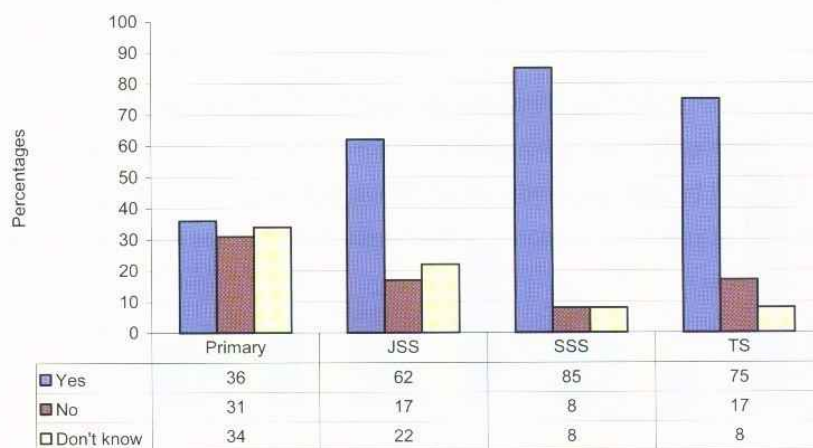


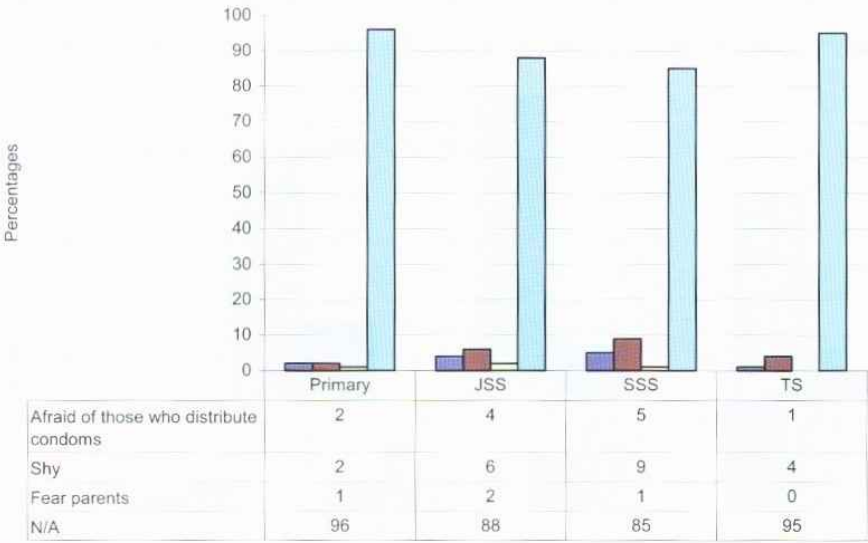
Figure 6.30 below shows that most students at all levels of education indicated that they could get condoms easily if they wanted them. However a significant number indicated that they could not and majority of these are primary school and junior secondary school students. Reasons given for failure to access condoms are shyness, fear of those who sell or supply condoms, health staff and parents' negative attitudes towards condom use by youth.

Figure 6.30 If You Wanted a Condom Could You Get it Easily



Although a small percentage of students indicated that shyness and fear of those who distribute condoms as reasons for lack of access to condoms, this percentage increases as one moves from primary to senior secondary schools (Figure 6.31).

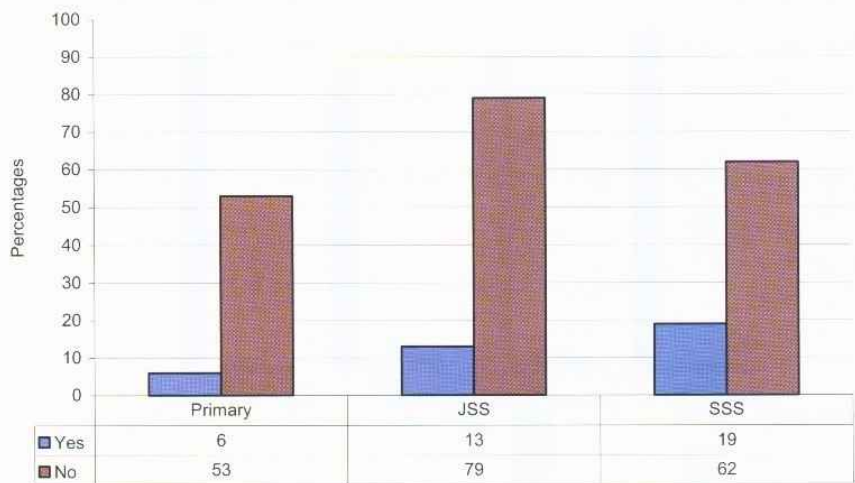
Figure 6.31 Reasons for Failing to Get Condoms



6.4.11 Multiple Sexual Partners

Lacking the necessary knowledge and skills, students who start having sex early are more likely to have sex with high-risk partners or multiple partners, and are less likely to use condoms. For HIV/AIDS to be contained among students and the youth in general they have to be taught the virtues of sticking to one faithful partner, as apposed to the risky behaviour of having multiple partners. From the field survey, majority of students indicated that they did not have multiple partners. However a few students do have multiple partners especially in junior and senior secondary schools (Figure 6.32). This highlights the fact that students in secondary schools engage in risky sexual behaviour. Furthermore, students responded in a similar manner to a follow up question to establish if students had serial partners in the last 12 months.

Figure 6.32 Multiple Partners in the Last 12 Months



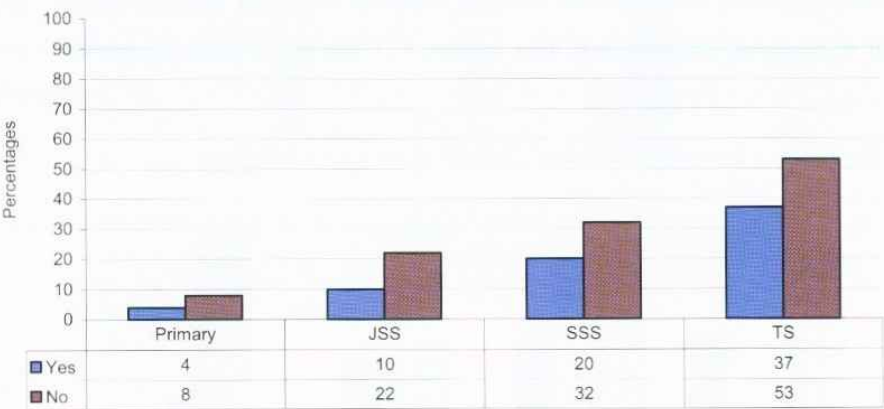
Most students indicated that they had never had sex with people 10 years older than them. However, in lower levels of education about 10% of students reported that they did. The percentage increases to about 16% in tertiary institutions. Furthermore, majority of students at all levels of education indicated to have had between 0-5 sexual partners in the last twelve months. However, a few especially in secondary schools have a high exchange rate of sexual partners (Table 6.16). In focused group discussions, it emerged that students in secondary schools engage in high risk sexual behaviour - unprotected group sex - which expose them to HIV.

Table 6.16 Number of Sex Partners in the Last 12 Months

	School Categories in Percentages			
Number of partners	Primary	JSS	SSS	TS
1-5	47	42	84	93
6 to 10	4	0	3	4
11 to 15	1	3	1	0
above 16	0	0	1	0
N/A	48	55	11	2
Total	100	100	100	100

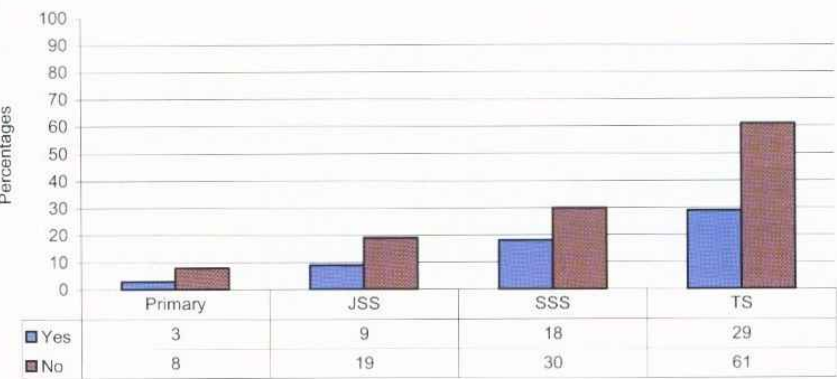
Majority of students reported that their sexual partners do not have other sexual partners, compared to those who say they think they do. A significant percentage of those who think their partners have other sexual partners were in senior secondary and tertiary schools (Figure 6.33).

Figure 6.33 A Partner Has Other Sexual Partners



About 3% of primary; 9% of JSS; 18% of SSS, and 29% of TS students have cheated on their sexual partners in the last twelve months. Cheating is more prevalent in high levels of education compared to lower levels. However, a good number of students did not cheat on their partners during the same period.

Figure 6.34 Incidence of Cheating on Partner over the Last 12 Months



6.4.12 Sexually Transmitted Diseases

Sexually transmitted diseases greatly facilitate HIV transmission between sexual partners, and young people who engage in risky behaviour are exposed to the danger of being infected with both. From the respondents, majority of students reported not to have had any sexual transmitted disease in the last 12 months. Somewhat few reported to have had sexually transmitted diseases, and more of these were in lower levels of education. Despite this, a small percentage of students indicated that they had an STD during the last 12 months (Figure 6.35).

Figure 6.35 Did You Have a Sexually transmitted Disease in the Last 12 Months

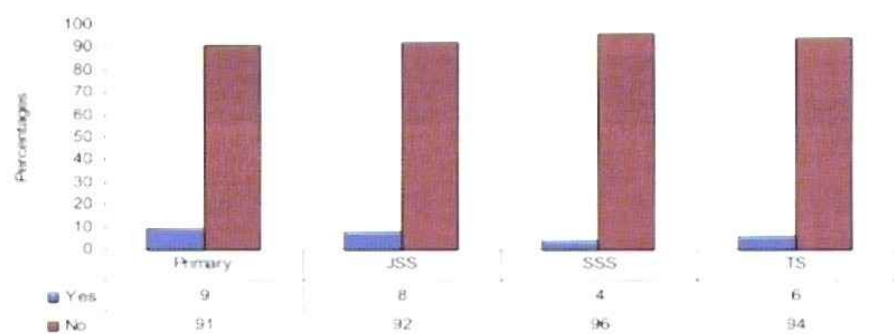


Table 6.4 shows that majority of students will seek advice from a health worker in a clinic or hospital if they had an STD. Traditional doctors are rated second by tertiary and primary students. About 44% and 19% of students respectively stated that they will seek help from traditional doctors (Table 6.17). For junior and senior secondary schools, the second option is to seek advice from friends and relatives, which is the third option for tertiary and primary students.

Table 6.17 What Will You Do if You Had an STD? (Percentages)

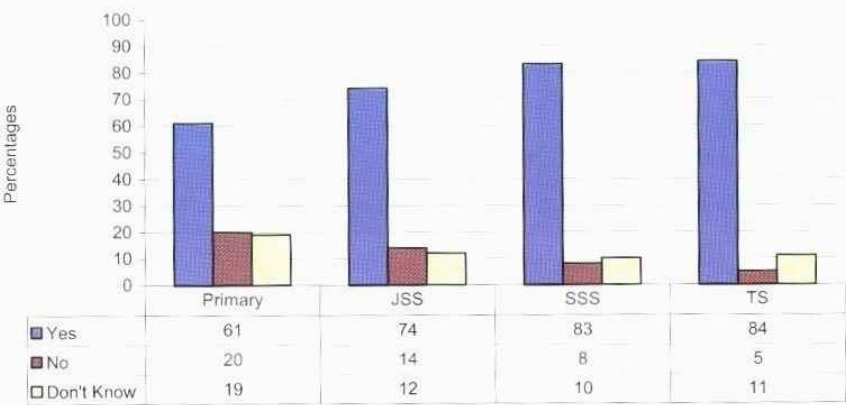
	Primary	JSS	SSS	TS
Seek advice from a health worker in a clinic or hospital	73	79	83	50
Seek advice or medicine from a traditional healer	19	13	12	44
Seek advice or buy medicines in a shop or pharmacy?	14	12	12	12
Ask for advice from friends or relatives?	18	21	19	20

Buying medicine is the last option for primary and tertiary students.

6.4.13 Stigma and Fear of Infection

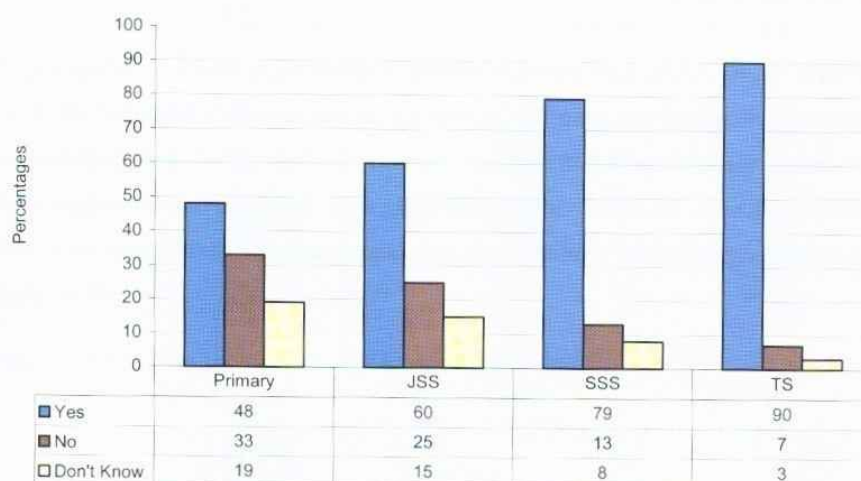
The fear of stigma and deep-rooted discrimination makes students less likely to adopt preventative strategies such as seeking testing for HIV and disclosing their HIV status to sexual partners, and caring for HIV or AIDS victims. However, the majority of students across education levels will care for relatives who are sick with AIDS in their homes. However, a significant few, especially in primary and junior secondary schools will not do that (Figure 6.36).

Figure 6.36 Will You Care For an AIDS Sick Relative in Your Home



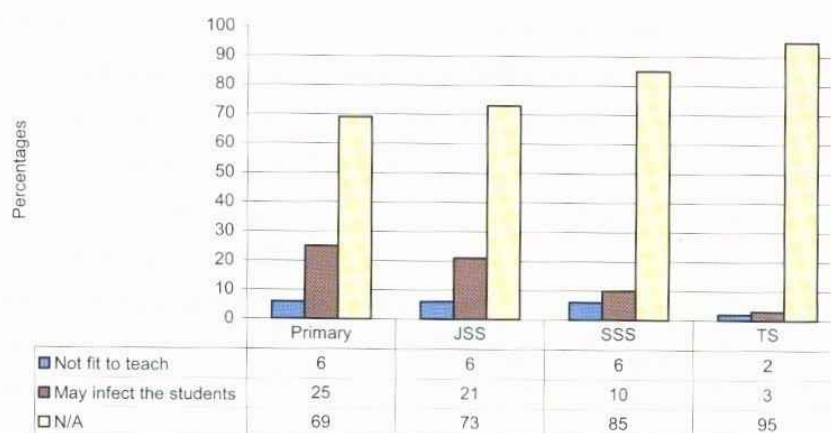
The few that will not care for their sick relatives stated that they would not do so because of fear of being infected. In addition, 48% of primary school students, 60% of junior secondary students, 79% of senior secondary students and 90% of tertiary students indicated that an HIV positive teacher who is not sick should be allowed to continue teaching in their schools. Again a significant few, especially from primary, junior and senior secondary schools are of the view that HIV positive teachers should not be allowed to teach in their schools (Figure 6.37).

Figure 6.37 Should an HIV Positive Teacher Who Be Allowed to Teaching in Your School



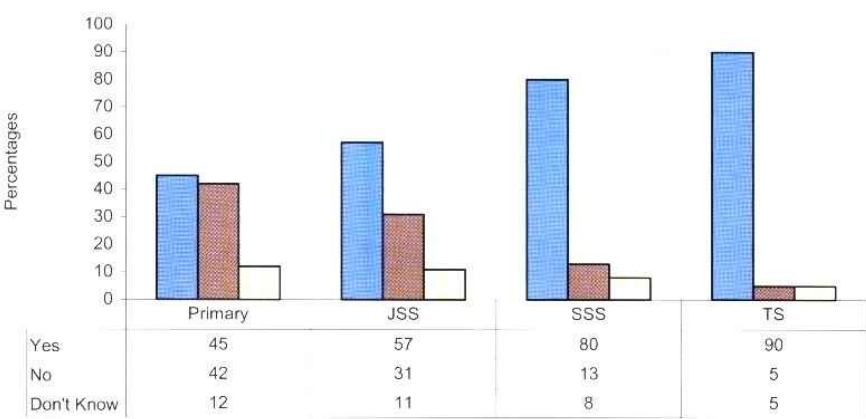
A few of those who do not agree that an HIV positive teacher should continue teaching are of the view that such teachers are not fit to teach and may infect students with the disease (Figure 6.38).

Figure 6.38 Why an HIV Positive Teacher Should Not Be Allowed to Teach



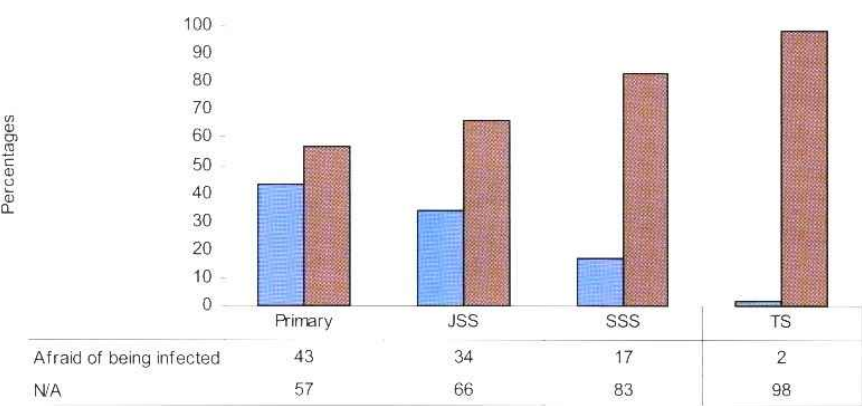
Furthermore, majority of students indicated that they will play with an HIV positive student. For primary schools 45% indicated they will play with HIV positive student compared to 90% of those at tertiary level. An equal number of primary students (42%) will not play with an HIV positive students. In other levels of education 31% of JSS, 13% of SSS and just 5% of TS students will not play with an HIV student. Again Figure 6.39 shows that the HIV/AIDS awareness levels are very low in lower levels of education, thus, explaining high levels of stigma towards those with the disease at these levels.

Figure 6.39 Would You Play with an HIV Positive Student



On a follow up question, again those who indicated that they will not play with HIV positive students indicated fear of being infected with HIV as the main reason (Figure 6. 40).

Figure 6.40 Why Would You Not Play With an HIV Positive Student



6.4.14 Sex Education

When asked whether or not particular statements describe the sex education they receive, students provided varying responses across education levels. Majority of students in tertiary schools agreed that sex education provide lessons on risks about unprotected sex whereas in lower levels of education what best described the sex education was lessons on HIV/AIDS.

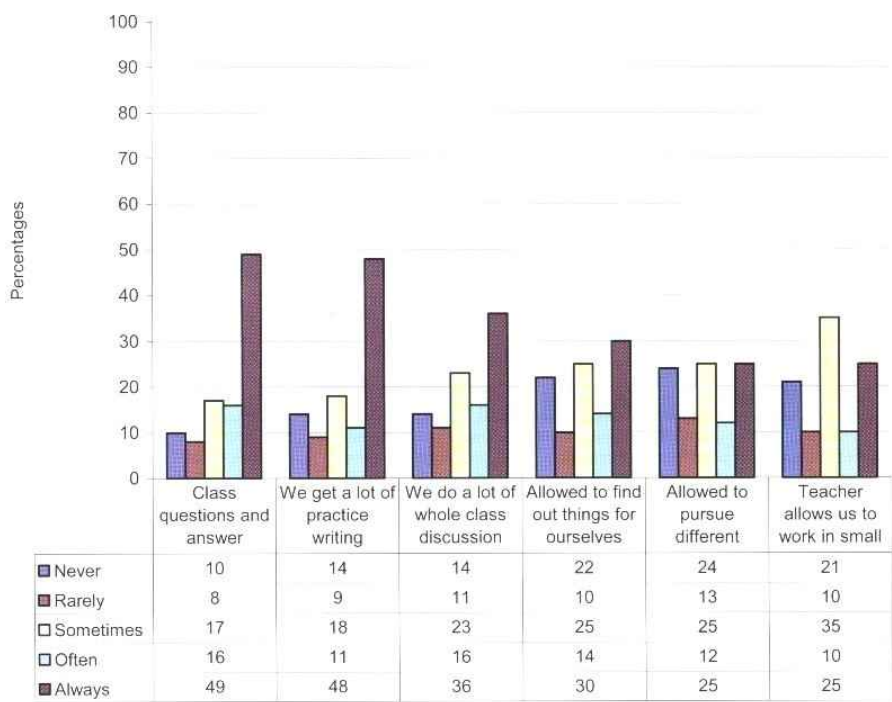
Table 6.18 Sex Education Received in Schools (Percentages)

	Primary	JSS	SSS	TS
Lessons about risks of unprotected sex	39	40	56	66
Lessons on HIV/AIDS	55	54	61	62
Lessons about condom use	43	41	45	54
Lessons on human sexuality	25	24	27	41
Lessons about healthy life styles	25	29	30	39

The second and third options that best describe sex education for primary, JSS and SSS students was lessons about condom use and about the risks of unprotected sex respectively (Table 6.18). Somewhat fewer students across education level say human sexuality and healthy life styles best describe the sex education they receive.

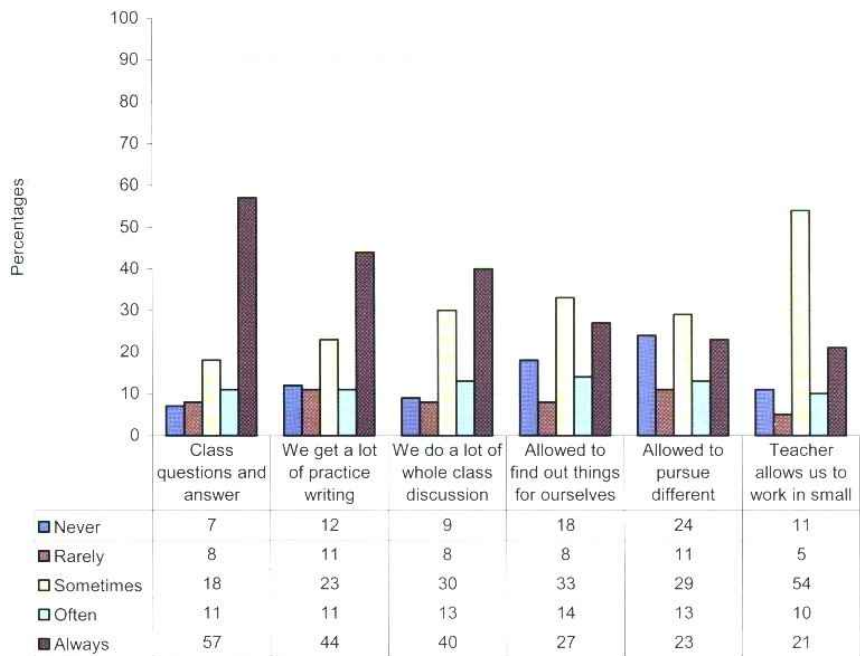
Students across all education levels perceive the most common teaching methods employed by teachers as follows in their order of importance: teacher asks the class questions and some answers, practise writing, whole class discussion, and working in small groups (Figure 6.41).

Figure 6.41 Methods of Teaching in Primary School



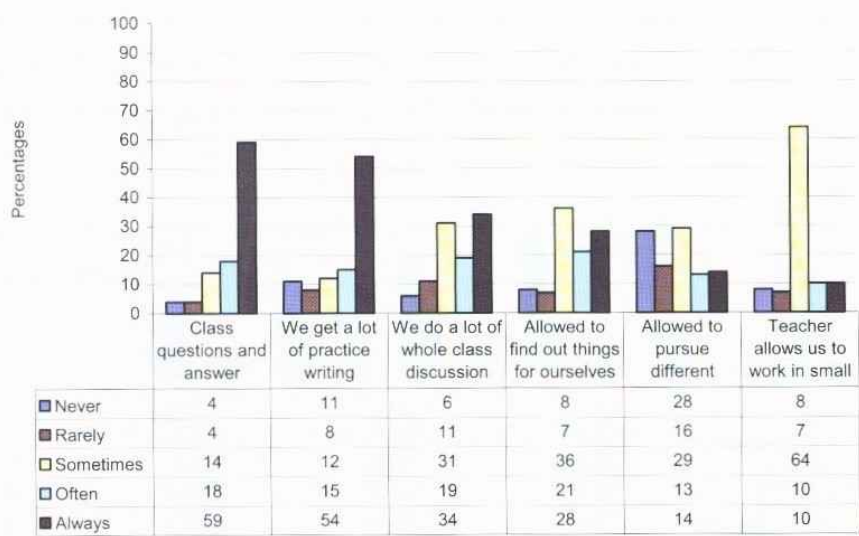
On average, teaching in primary schools takes the form of questions and answers (49%), followed by practising writing (48%), class discussion (36%) and students finding out things for themselves (30%). It seems that interactive learning such as pursuing different things and working in small groups are not methods commonly applied by teachers. A similar pattern is depicted by secondary schools except that less emphasis on students pursuing different things or working in groups (Figures 6.42-44).

Figure 6.42 Teaching methods in JSS



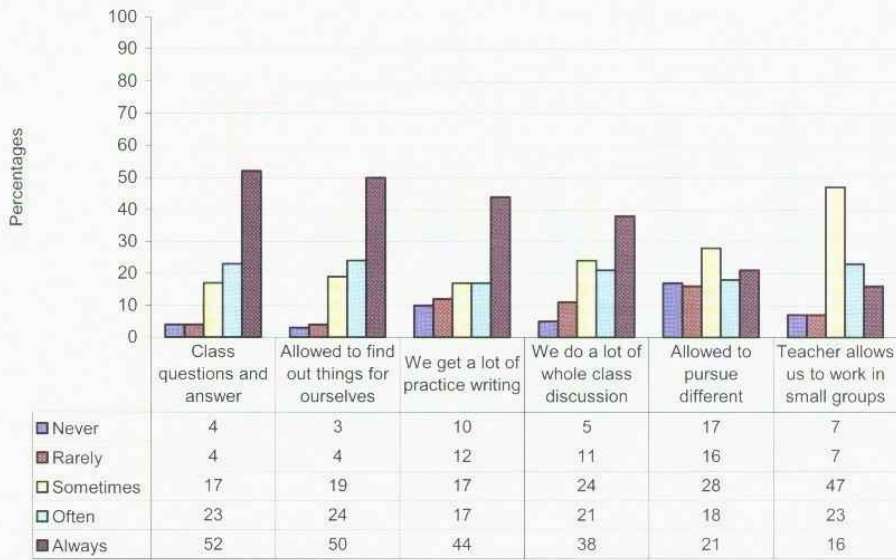
At junior secondary schools, chances of pursuing different things and working in small groups are 23% and 21% respectively, which is a drop from 25% for primary schools. There is seems to be more emphasis on question and answer system (Figure 6.42).

Figure 6.43 Teaching Methods in SSS



For senior secondary schools, the percentage of students who indicated that they are allowed to pursue different things and work in small groups fall to 14% and 10% respectively as compared to junior secondary schools (Figure 6.43).

Figure 6.44 Teaching Methods in TS



The same similarities are apparent in tertiary institutions, where more emphasis is place on questions and answers (52%), students finding things on their own (50%) and very little emphasis paced on class discussions (38), pursuing different things (215 and working in small groups (16%).

6.4.15 Sources of Care and Support for Persons Living With HIV/AIDS

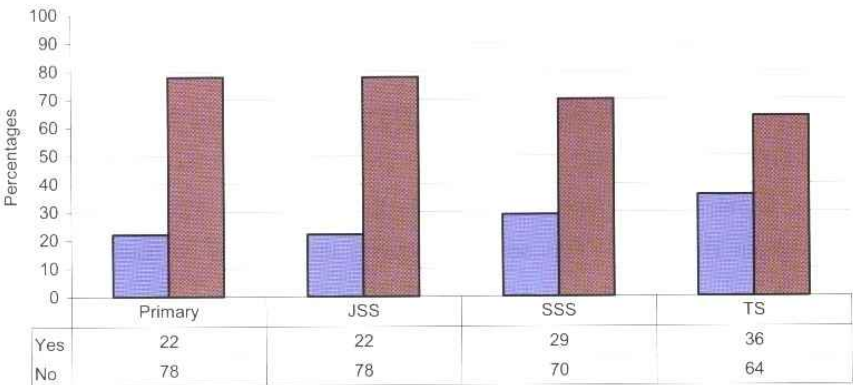
Table 6.19 below shows that more than half of primary and junior secondary students reported that they are receiving very good treatment from health facilities in the country. The percentage falls below half in senior secondary and tertiary schools. In tertiary institutions, the majority of students rated the treatment they receive from health facilities as average.

Table 6. 19 The Treatment Students Received at Health Facilities (Percentages)

	Primary	JCSS	SSS	TS
Very good	57	55	36	20
Good	19	24	30	28
Average	11	10	24	43
Poor/Not good at all	13	11	10	10

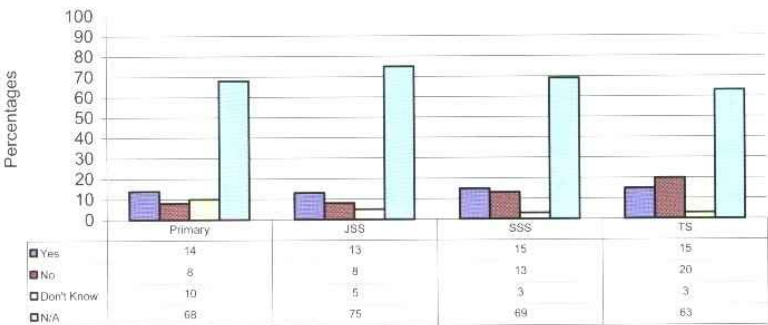
More than 70% of students across education levels reported that none of their family members were sick or died after being sick for more than 3 months in the last 12 months (Figure 6.45). However, a significant minority across education levels reported members of their family as having been sick and/or died in the last 12 months.

Figure 6.45 Family Member Have Been Sick or Died After Being Sick 3 Months or More in the Last 12 Months



About 14% of those whose members of their household were sick received help from outside the household. Other students did not know if they received outside help or not while the question was not applicable to the majority of students.

Figure 6.46 .Help Received From External Source to the Household for the Sick



6.5 TEACHERS' KNOWLEDGE, ATTITUDES AND PERCEPTIONS ABOUT HIV/AIDS

The previous section discussed perceptions, attitudes and knowledge of HIV/AIDS among students in selected schools. Making students more aware at an early age about the issues surrounding HIV/AIDS is one way to overcome ignorance and preconceived notions about HIV/AIDS and ultimately achieving an HIV/AIDS free society by the year 2016. Schools are the main way of imparting information about HIV/AIDS to students. The GOB equally feels that schools must play a role in the effort to control or eventually stop this disease by 2016. Schools serve million of students, and school-based HIV/AIDS programmes may also be the only formal instruction which Batswana will receive on this critical health problem in their lives. Therefore, it was found equally important to assess the knowledge, attitudes and perceptions of teachers about HIV/AIDS. This section discusses the findings on teachers' perceptions, attitudes and knowledge of HIV/AIDS. It specifically discusses the socio-economic profile of teachers, their knowledge of HIV/AIDS, behaviour, and the stigma they associate with HIV/AIDSs.

6.5.1 Socio-Demographic Profile

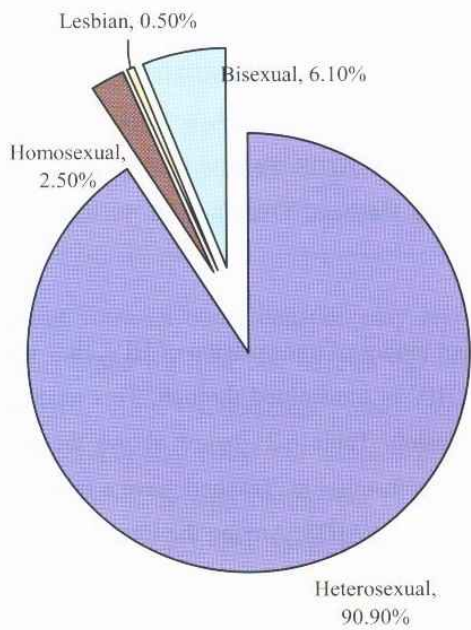
This section presents the socio-demographic profile of the teachers interviewed during the survey. A total of 1731 teachers were covered by the baseline survey and all the questionnaires were self-administered. Of these, 68.6% were female and 31.4% male. About 49.9% were residing in urban areas while 50.1% hailed from peri-urban and rural areas. The proportion of males and females in both the urban and rural samples were similar to the overall proportion. The median age of respondents was 29 years for females and 30 years for males for the entire sample. The median age ranged between 28-30 years for the individual areas and for males/females and urban/rural areas. The largest proportion of the sample was composed of individuals aged 25-40 years. Nearly a third of teachers in the survey were currently married (55.7 %). A higher proportion of females and rural residents were currently married compared to males and urban residents respectively. The rest 35.3% are single while 4.1% are cohabiting, 1.1% separated, 1.5% divorced and 1.7% widowed (Table 6.20).

Table 6.20 Marital Status of Teachers

Marital Status of Teacher	Percent
Married	55.7
Single	35.9
Cohabiting	4.1
Separated	1.1
Divorced	1.5
Widowed	1.7
Total	100

Majority of teachers identified their sexual orientation as heterosexual (90.9), with 2.5% of teachers identifying themselves as homosexual, 0.5 % as lesbian, and finally 6.1% as bisexual (Figure 6.47)

Figure 6.47 Sexual Orientation of Teachers



All teachers who identified their sexual orientation as anything other than heterosexual are all from urban areas, with 90% of them from Gaborone alone. This may reflect the level of

tolerance in urban areas about people who have different sexual orientation other than what is perceived to be the norm.

Most of the teachers covered by the survey teach at primary level (63.9%), CJSS account for 18.2%, senior secondary schools account for 8.9% and tertiary institutions account for 9.1% of the teachers covered by the baseline study. In terms of training, an overall 4.1% of the teachers were temporary, the rest were qualified teachers. This means that average literacy levels of the sampled teachers is high. Number of years in teaching ranged from 1 to 40 years, with modal length of teaching being 2 and 10 years.

6.5.2 Knowledge of HIV/AIDS by Teachers

The TCB projects focuses on the teacher as the main player in imparting knowledge to students. Teachers can impart such knowledge if they are also adequately trained to impart such knowledge. The TCBP baseline study is meant to assess the extent of knowledge about HIV/AIDS among teachers before the beginning of the project in order to do proper targeting during the implementation of the project. The study found that teachers possessed a fairly good understanding of HIV/AIDS. Teachers' attitudes toward HIV/AIDS were generally positive. Results indicated a direct relationship between teachers' knowledge of HIV/AIDS and positive or supportive attitudes toward HIV/AIDS. Female teachers hold more positive attitudes toward HIV/AIDS than do male teachers. Overall, 100 % had ever heard of HIV/AIDS.

To gauge the knowledge of teachers about modes of transmission of HIV, they were asked to choose the different ways they believe HIV is transmitted through. This means they could choose more than one mode of transmission. Table 6.21 below shows the percentage of teachers who chose the different modes of transmission. Teachers have a fairly high level of knowledge about modes of transmission of HIV/AIDS. Among the interviewed teachers, the modal mode of transmission of HIV was unprotected sex (97.6 %), followed by sharing needles in taking street drugs (81.9%), sharing needles in tattoos (68.1%) and blood donation (67.6%). The other modes transmission registered less than 50% of the votes. Some teachers harboured some incorrect beliefs regarding transmission of HIV/AIDS. This is reflected by

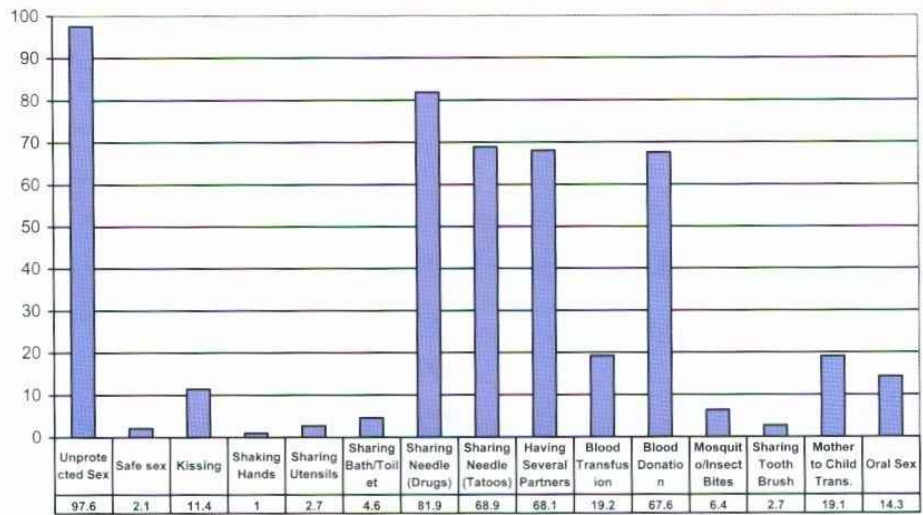
11% of the interviewed teachers who indicated that HIV/AIDS could be transmitted through kissing and 6% said through mosquito bites.

Table 6.21 Modes of Transmission of HIV

Transmission Method	Percent	Male	Female
Unprotected Sex	97.6	22.38	77.62
Safe sex	2.1	98.02	1.98
Kissing	11.4	88.55	11.45
Shaking Hands	1	99.07	0.03
Sharing Utensils	2.7	97.55	2.55
Sharing Bath/Toilet	4.6	95.41	4.59
Sharing Needle (Drugs)	81.9	17.79	82.21
Sharing Needle (Tatoos)	68.9	30.81	69.19
Having Several Partners	68.1	31.74	68.26
Blood Transfusion	19.2	80.87	19.13
Blood Donation	67.6	32.15	67.85
Mosquito/Insect Bites	6.4	93.72	6.28
Sharing Tooth Brush	2.7	97.96	2.4
Mother to Child Transmission	19.1	80.87	19.13
Oral Sex	14.3	84.65	15.35

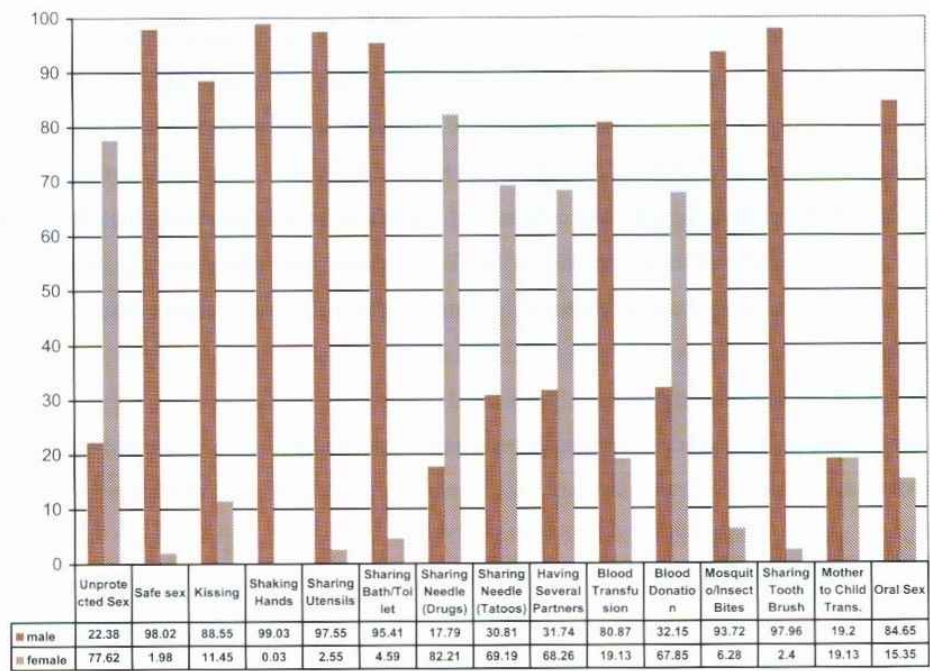
The high percentage of votes on blood donation may represent the fears that individuals harbour about donating blood e.g. fear that needles that are used to draw blood might be contaminated with HIV virus. Nonetheless, misconceptions prevail among teachers concerning the transmission of HIV virus. For instance, people have been repeatedly assured that HIV cannot be transmitted through kissing, but 11.4% of the teachers still think can be transmitted that way (Figure 6.48). The same applies to sharing utensil (2.7%), sharing toilet/bath (4.6%), mosquito bites (6.4%), etc. Blood transfusion registered a 19.2%, which may also be indicative of the fears people may have about contamination or lack of screening of blood (Figure 6.48).

Figure 6.48 Modes of Transmission of HIV



A very interesting picture emerges when we assess the knowledge of transmission of HIV by sex. There seems to be serious gender disparities in terms of knowledge of modes of transmission of the virus. Pooling data from all regions, 22% males and 78% females were aware of that HIV may be transmitted through unprotected sex. A similar pattern is registered with safe sex, sharing needles for shooting drugs and for tattooing, and blood donation. Male teachers seem to have more misconceptions about the transmission of the HIV than female teachers. Figure 6.49 below shows the gender distribution of the perceived HIV transmission modes.

Figure 6.49 Gender Distribution of Modes of Transmission of HIV



More male teachers voted for modes that are considered misconceptions about HIV transmission. Unless the male teachers did not understand what is meant by safe sex, 98% of them voting for it as a way of transmitting HIV shows that they lack knowledge about modes of transmission. This misconception about this route of transmission of HIV is very low among female teachers. Only 2% of female teachers indicated it as a mode of transmission of HIV (Figure 6.49). This gender split is apparent with regard to other ways that are considered to misconceptions about the transmission of HIV. For example, more male teachers chose shaking hands (male 99% - female 1%) , kissing (male 88% -female 22%) sharing utensils (male 97%- female 3%) as modes of transmission of HIV than female teachers Figure 6.49. Again fewer male teachers chose ways that are considered transmission routes of HIV. For example, fewer males chose sharing needles for shooting drugs (male 17% -female 83%), sharing needles for tattooing (male 30% -female 70%) and having several partners (male 31% - female 69%) as modes of transmitting HIV.

To further check the differences between male and female teachers, we correlated personal attributes with modes of transmission of HIV. While the coefficient of covariance has no upper and lower limits, the coefficient of correlation can vary from positive one (indicating a perfect positive relationship), through zero (indicating the absence of a relationship), to negative one (indicating a perfect negative relationship). As a rule of thumb, correlation coefficients between 0.00 and 0.30 are considered weak, those between 0.30 and 0.70 are moderate and coefficients between 0.70 and 1.00 are considered high. The primary meaning of the coefficient of correlation lies in the amount of variation in one variable that is accounted for by the variable it is correlated with. We focused the discussion of the coefficient of correlation mainly on significant relationships. Table 6.22 below shows results for female teachers.

Table 6.22 Correlation Between Modes of Transmission and Personal Attributes – Female

Transmission Method	Age	Marital status	Sexual Orientation	Teaching Level	Position	Experience (Years)
Unprotected Sex	-.014	.003	.001	-.030	.008	-.009
Safe sex	.024	.054	.038	.004	.017	.070*
Kissing	.109**	.011	-.030	.031	-.033	.085**
Shaking Hands	.064*	.006	-.016	.029	-.044	.116**
Sharing Utensils	.073*	.022	.017	.028	.022	.058
Sharing Bath/Toilet	.140**	.079**	.032	.031	-.024	.168**
Sharing Needle (Drugs)	-.033	.000	-.010	-.028	-.041	-.026
Sharing Needle (Tatoos)	.099**	-.004	.038	-.103**	-.031	-.079**
Having Several Partners	.104**	.031	.008	-.011	.040	.087**
Blood Transfusion	.156**	.116**	.074*	.005	.044	.119**
Blood Donation	.006	-.039	.077*	-.066*	.096**	.007
Mosquito/Insect Bites	.059	.128**	.061	-.031	.010	.067*
Sharing Tooth Brush	.041	.029	.079*	-.144**	.087**	.020
Mother to Child Transmission	-.046	.033	-.078*	-.019	-.015	-.053
Oral Sex	.022	.026	-.072*	-.002	-.002	.015

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

The perception that HIV can be transmitted through unprotected sex is weakly correlated with all personal attributes of female teachers observed in the study. This is in contrast to male teachers, where by unprotected sex is significantly associated with marital status, level at which the teacher teaches and position in school. We ranked marital status in an ascending order, from single to divorced i.e. single=1, cohabiting=2, married=3, separated=4, divorced=5 and treated being widowed as single. For male teachers, unprotected sex has a negative significant correlation with marital status at 1% significance level. This means as one moves from being single to other forms of marital status the perception that HIV can be spread through unprotected sex wears off. This actually means male teachers who are single strongly believe that unprotected sex spread HIV more than those who married or even divorced. The same applies to the level at which the teacher teaches, as one moves from tertiary to primary school, male teachers believe unprotected sex can spread HIV becomes weaker. What this means is that male teachers at higher levels of education believe strongly that unprotected sex spreads HIV more than those at lower levels of education. However, position of teacher is positively and significantly correlated to unprotected sex (Table 6.22). This means that increase in seniority increases the perception of risky, the senior the male teacher is, the more likely he believes that unprotected sex spreads HIV.

For female teachers safe sex is positively and significantly associated with experience (years of teaching) while it is significantly associated with position of teachers for male teachers. This means that for female teachers, the belief that safe sex transmit HIV gets stronger as one gains more experience in teaching while it gets stronger for male teachers as they become senior in teaching. Kissing has a positive and significant correlation with age and experience for female teachers (correlation coefficient of 0.07, which is significant). Age also has a positive significant relationship with shaking hands, sharing utensils and sharing toilet (Table 6.18). This implies that age somehow reinforces misconceptions about the spread of HIV among female teachers, the older one gets the more misconceptions about HIV/AIDS. For male teachers, age is significantly correlated with misconceptions about the spread of HIV that are different from those of female teachers. For male teachers, age has a positive and significant correlation coefficient with taking antiretroviral medication and vaccination. The older one is, the more he believes that HIV can be spread through vaccination and taking antiretroviral medication.

Marital status does not seem to have much influence on beliefs concerning modes of HIV transmission. For female teachers, marital status has positively and significantly correlated with sharing bath/toilet, blood transfusion and mosquito or insect bites (Table 6.23). For male teachers, marital status is negatively correlated to unprotected sex, sharing needles for shooting drugs and sharing needles for tattoos, and positively correlated to sharing bath or toilet and mother-to-child transmission (Table 6.23). The same applies to experience, the more years in teaching, the more likely the female teacher believes HIV is spread through safe sex, kissing, sharing utensils, sharing bath or toilet, having several partners, blood transfusion and mosquito bites. For male teachers, the more years of teaching, the more likely he believes HIV is spread through sharing bath or toilet and having several partners and the less likely he believes that HIV is spread through sharing needles and blood transfusion. Generally, there is a disparity between male and female teachers in regard to perception about the spread of HIV/AIDS. Furthermore, male teachers seem to be knowledgeable about modes of transmission of HIV, more so those at lower levels of education.

Table 6.23 Correlation Between Modes of Transmission and Personal Attributes – Male

	Age	Marital status	Sexual Orientation	Teaching Level	Position	Experience (Years)
Unprotected Sex	-.070	-.123**	.049	-.101*	.102*	.000
Safe sex	.087	-.023	-.028	-.018	.106*	.078
Kissing	-.012	.005	-.025	-.164**	.112*	-.032
Shaking Hands	-.002	-.037	-.049	.046	-.052	.059
Sharing Utensils	-.045	-.015	-.034	-.063	.051	-.021
Sharing Bath/Toilet	.042	.163**	-.009	-.056	.112*	.093*
Sharing Needle (Drugs)	-.102*	-.113**	-.014	-.037	.056	-.141**
Sharing Needle (Tatoos)	-.035	-.138**	.007	-.090*	.077	-.067
Having Several Partners	.149*	.004	.106*	-.057	.057	.150**
Blood Transfusion	.150*	-.024	-.035	-.028	.054	-.117**
Blood Donation	.057	-.019	-.011	-.081	.007	.042
Mosquito/Insect Bites	-.042	.003	-.060	-.034	.038	.049
Sharing Tooth Brush	.063	.069	-.045	.098*	-.005	.063
Mother to Child Transmission	-.046	.096*	-.062	.055	-.010	-.052
Oral Sex	-.028	.030	-.050	.025	-.003	-.016

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Correlation coefficients were also computed for the relation between prevention methods and personal attributes of teachers. Teachers were asked what one can do to avoid being infected with the HIV. Table 6.20 and Table 6.21 below present results for female and male teachers respectively. For female teachers, age is significantly and positively correlated with prevention of HIV using antiretroviral medication, sex with several partners and vaccination compared to male teachers whereby age is positively correlated to having sex with a virgin. Again we see that misconception about the prevention of HIV/AIDS exist among teachers. However, misconceptions are different among male and female teachers. While male teachers significantly believe that one can prevent HIV/AIDS by having sex with a virgin, female significantly believe antiretroviral medication and vaccination and prevent infection with HIV. For male teachers age has negative significant relationship with sticking to one partner. The older a male teacher, the less he believes that sticking one partner can prevent the spread of HIV.

Table 6.24 Correlation Between Prevention and Personal Attributes –Female Teachers

	Age	Marital status	Sexual Orientation	Teaching Level	Position	Experience (Years)
Using Condoms	-.010	-.026	-.028	.037	-.046	.023
Sticking to One Partner	.045	.010	-.024	.059*	-.048	.088**
Abstain from sex	-.020	-.048	.066*	-.006	-.015	-.003
Antiretroviral Medication	.103**	-.036	.054	.002	.048	.056
Sex with a Virgin	.058	-.016	.072*	-.008	.007	.000
Sex With Several Partners	.119**	-.030	.014	.019	.018	.065*
Consult Traditional Doctor	.050	.001	.063	.029	-.028	.022
Vaccination/Immunisation	.091**	.001	.084*	.035	.015	.017
Using Gloves	-.044	-.012	-.003	.045	-.036	-.038

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

There is no significant correlation between marital status and prevention methods of HIV for female teachers. For male teachers, marital status and antiretroviral medication have a negative and significant correlation, implying that single people believe that antiretroviral medication prevent HIV infection more than those who are married or divorced.

Having several partners and marital status has a positive and significant coefficient of correlation for male teachers (Table 6.24). This implies that as one moves from being single to being married, cohabiting or divorced, it is more acceptable that having several partners can prevent infection with HIV.

Results for sexual orientation for female teachers show that moving from being heterosexual to other forms of sexuality reinforces believe that abstaining from sex can prevent the spread of HIV (positive and significant coefficient of 0.066). However, misconceptions exist are female teachers concerning HIV prevention. There is positive and significant correlation between vaccination and sexual orientation, implying that believe that vaccination prevents the spread of HIV is stronger among teachers who are not heterosexual (Table 6.25).

Table 6.25 Correlation Between Prevention Methods and Personal Attributes –Male Teachers

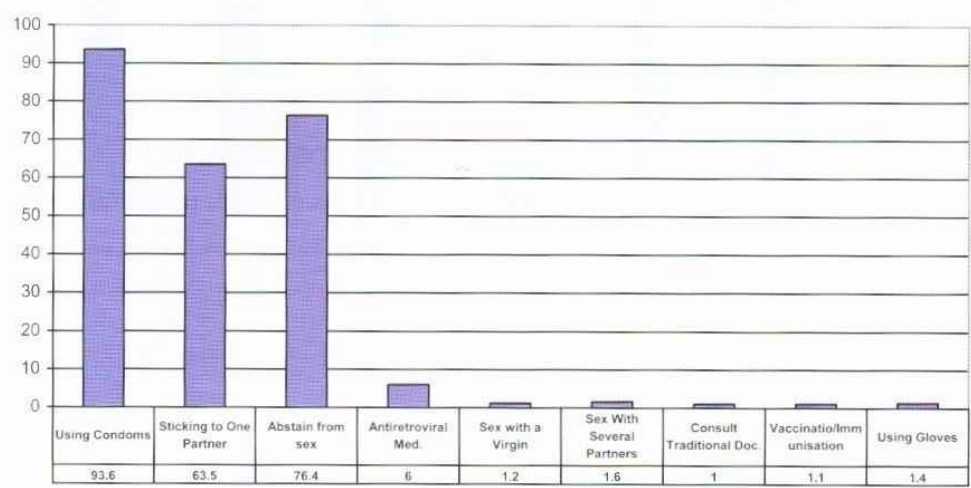
Using Condoms	Age	Marital status	Sexual Orientation	Teaching Level	Position	Experience (Years)
Sticking to One Partner	-.100*	-.070	.073	.009	-.040	-.063
Abstain from sex	.066	-.073	.057	-.093*	.125**	.046
Antiretroviral Medication	.044	-.151**	.097*	-.032	.018	.058
Sex with a Virgin	.093*	-.037	.022	.000	.008	.064
Sex With Several Partners	.065	.098*	-.033	-.022	.016	.034
Consult Traditional Doctor	.066	-.030	-.042	.048	-.005	.017
Vaccination/Immunisation	.018	-.054	-.036	.079	-.054	-.059
Using Gloves	.027	-.072	-.052	.056	-.038	-.045

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

The level at which a teacher teaches has positive and significant coefficient of correlation with sticking to one partner for female teachers. This implies that if one moves from being a primary school to be a teacher at a higher level of education, the perception that sticking to one partner prevents infection with HIV gets stronger for female teachers. The education at which a male teacher teaches has a negative and significant coefficient correlation with abstaining from sex. The implication is that the teachers at lower levels of education are the less likely to believes that abstaining from sex can prevent HIV/AIDS than those at senior levels of education. Based on these results, male teachers are less knowledgeable about the transmission of HIV than female teachers.

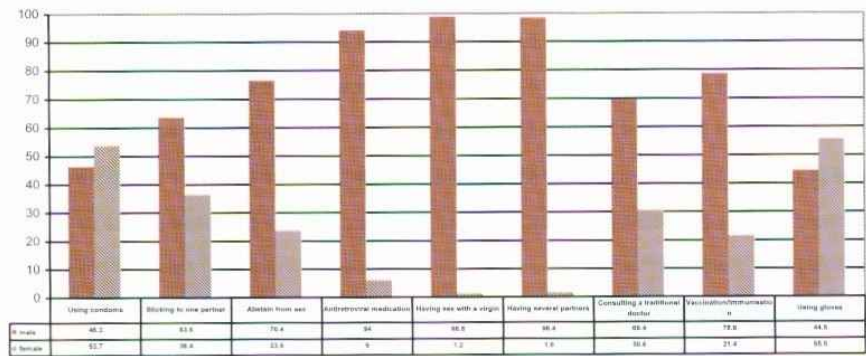
Figure 6.50 below shows the responses of teachers with regard to each perceived method of prevention of the spread of HIV/AIDS. A minute percentage of the interviewed teachers indicated that using glove (1.4%) when touching an infected person can prevent the spread of HIV. Misconceptions regarding the prevention of HIV/AIDS seem to be prevalent among teachers. Among the interviewed teachers, only 65% indicated that HIV can be prevented by taking antiretroviral therapy. However, some believe that sex with a virgin (1.2%), sex with several partners (1.6%), consulting traditional doctors (1%) and vaccination can prevent HIV.

Figure 6.50 Methods of Preventing Infection



Misconceptions about HIV transmission seems to correlated with those about prevention. Figure 6.51 shows that male teacher take the lead in misconceptions about the prevention of HIV/AIDS. Male teacher account for a large percentage with respect to preventing HIV/AIDS by using antiretroviral medication (male 94%- female 6%), having sex with a virgin (male 98% - female 2%), having several partners (male 98% - female 2%), consulting a traditional doctor (male 69% - female 31%) and vaccination (male 78% -female 22%).

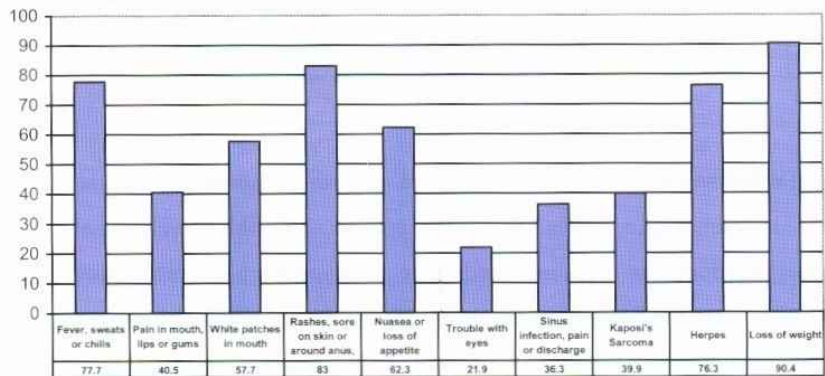
Figure 6.51 Sex Distribution on Ways of Preventing HIV/AIDS



6.5.2.1 Knowledge of Symptoms of AIDS

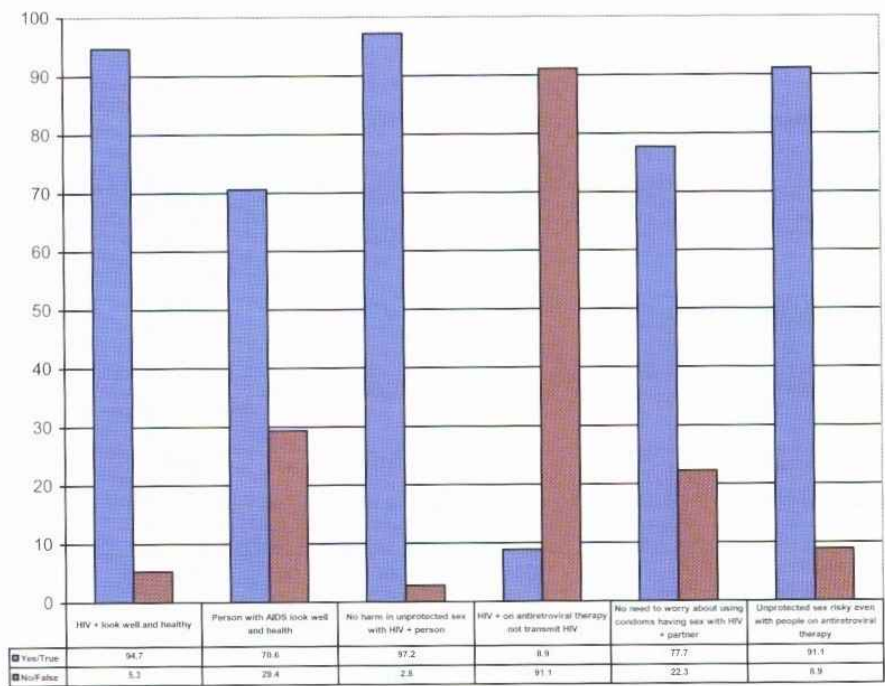
Teachers were asked to tick what they consider to be symptoms of AIDS from the list options. Figure 6.52 below shows how teachers voted on different options. Loss of weight ranked very high (90%), followed by sores on skin or around anus or penis (83%), herpes (76%), and fever or chills (62%). Trouble with eyes was voted the least (21%).

Figure 6.52 Symptoms of HIV/AIDS



To assess the awareness and knowledge of teachers about common symptoms of AIDS, teachers were asked to respond yes and no or true or false statements. Figure 6.53 below shows how teachers responded to the statements.

Figure 6.53 Extent of Knowledge About HIV/AIDS



Although a large percentage of teachers answered most statements correctly, it is alarming that a large percentage (97%) of teachers indicated that it is true that there is no harm in having sex with an HIV positive person. We correlated the responses with the personal attributes of a teacher, and an interesting picture emerges between male and female teachers, with male teachers views being somewhat different from those of female teachers. According to Table 6.26 below shows that older teachers do not think that an HIV positive person can look well and healthy, and this applies to both male and female teachers. Older female teachers also significantly do not believe that someone with AIDS can look well and be healthy. Marital status does not seem to significantly affect the way female teachers think about HIV/AIDS compared to male teachers. For the latter, marital status is positively and significantly correlated with the statement that says “a person with AIDS looks well and health.” This implies that as one moves from status of being single to being married or cohabiting he believes more that a person with AIDS look well and healthy becomes stronger.

Table 6.26 Correlation Between Beliefs About HIV/AIDS and Personal Attributes

Female Teachers	Age	Marital status	Sexual Orientation	Teaching Level	Position	Experience (Years)
HIV + person look well and healthy	-.148* *	.016	.056	-.122**	.032	-.018
Person with AIDS look well and health	-.069*	.000	.008	-.019	-.007	.065*
No harm in unprotected sex with HIV + person	-.026	-.025	.025	.022	-.049	-.016
HIV + person on antiretroviral therapy not transmit HIV	.010	.005	-.035	-.123**	-.080**	-.082*
No worry using condoms when sex partner is HIV+	.015	.012	.040	.236	.172	.041
Unprotected Sex risky with persons on antiretroviral drug therapy	.097	.121	.194	.341	.058	-.67
Male Teachers						
HIV + person look well and healthy	-.106*	.048	.096*	.021	.040	-.012
Person with AIDS look well and health	-.065	.104*	.002	.103*	-.101*	-.002
No harm in unprotected sex with HIV + person	-.031	.014	.037	.036	.062	-.055
HIV + person on antiretroviral therapy does not transmit HIV	.009	-.105*	-.040	-.122**	-.058	.018
No need to worry about using condoms having sex with HIV+ person	.066	-.76	.57	-.93	.125	.046
Unprotected Sex risky with persons on antiretroviral drug therapy	.037	.398	.636	.162	.065	.016

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

The data was further analysed in terms of tertiary, SSS, JCSS and primary schools to assess if there is any disparity in knowledge of HIV/AIDS among teachers. Table 6.27 below presents the results on educational level and the response of teachers. There seems to be a high level of awareness about the way an HIV positive person looks and feels among all teachers. In all school categories, more than 90% of the teachers indicated that it is true that an HIV positive person can look and feel health.

Table 6.27 Level of Education and Response of Teacher

	Tertiary		SSS		JCSS		Primary	
	Y/T ²	N/F	Y/T	N/F	Y/T	N/F	Y/T	N/F
HIV + person look well and healthy	93.2	6.8	96.2	3.8	96.2	3.8	95.5	4.5
Person with AIDS look well and health	29.7	70.3	34.8	65.2	25.8	74.2	24.0	76.0
No harm in unprotected sex with HIV + person	98.5	1.5	98.1	1.9	98.4	1.6	97.9	2.1
HIV + person on antiretroviral therapy not transmit HIV	82.6	17.4	82.4	17.6	77.4	22.6	65.5	34.5
No need to worry about using condoms when having sex with HIV+ person	0	100	2.2	97.8	1.6	98.4	3.6	97.4
Unprotected sex risky with persons on antiretroviral drug therapy	14.9	85.1	12.1	87.9	4.9	95.1	8.9	91.1

Y/T = Yes/No and N/F=No/False

A similar pattern of response persists across all level of education in regard to the statement that teachers were asked to respond to except that primary school teachers seem less knowledge about HIV/AIDS related issues than the teachers in higher levels of education. In some respects primary school teachers seem to have the same level of knowledge as tertiary level teachers. This may be explained by the fact that teachers at these levels of education may have more or less the same level of training.

5.6.2.1 Composite Indicator of Knowledge for Teachers

To assess the overall knowledge of teachers about HIV transmission, composite indicators were developed by dividing teachers who both correctly identified ways of preventing the sexual transmission of HIV and those who rejected major misconceptions about HIV transmission by the number of teachers who gave answers. Indicators are percentages of teachers disaggregated into age groups and education level, and have been calculated for individual questions and by aggregating all questions.

6.27a Teacher Data disaggregated into Age Groups

Age Groups	Numerator	Denominator	Indicator (%)
16 – 25	110	185	59.5
26 – 35	410	739	55.5
36 – 45	232	428	54.2
46 – 55	83	150	55.3
56 – 65	14	28	50.0
Above 65	0	2	0
TOTAL	849	1532	55.4

From Table 6.27a, the composite indicators show that overall teachers' knowledge of HIV transmission is as high as 55%. Furthermore, teachers aged 16-25 years are more knowledgeable about HIV transmission and prevention compared to those aged 56-65 years. In other words, the level of awareness declines from age 16 to age 65. This could suggest that the attentiveness in absorbing HIV/AIDS related information declines as the teacher gets older.

Disaggregating by level of education at which one teaches shows that primary school teachers are more knowledgeable than the rest of teachers (Table 6.27b). Compared to students, the level of awareness about HIV transmission and prevention seems to be negatively related to the education level. That is, teachers at tertiary institutions are less informed compared to those at primary and CJSS. Overall the composite indicators are very

low, thus suggesting that correct knowledge of modes HIV transmission and prevention are low among teachers though slightly better for those who teach at primary and CJSS.

6.27b Indicator by Level of Education at which Respondents Teach

School Level	Numerator	Denominator	Indicator (%)
Tertiary	74	135	54.8
SSS	81	161	50.3
CJSS	174	314	55.4
Primary	620	1120	55.4
TOTAL	949	1730	55.9

As for the individual questions, indicators for question 1 show that teachers who are aged 56-65 years lead in the belief that the risk of HIV transmission can be reduced by having sex with only one faithful partner. The indicators for questions 2 and 3 shows that there is a high level of awareness that the risk of HIV transmission can be reduced by using condoms and that a healthy looking person can have HIV (Table 6.27c).

Table 6.27c Score for Individual Questions Disaggregated Into Age Groups (Percentages)

Age Group	Q1 Indicator	Q2 Indicator	Q3 Indicator	Q4 Indic.	Q5 Indic.
16 – 25	67.0	92.4	96.8	94.1	97.8
26 – 35	61.0	95.5	96.8	95.4	97.6
36 – 45	62.4	93.2	96.3	92.1	98.4
46 – 55	73.3	90.7	88.7	92.0	96.0
56 – 65	78.6	92.9	75.0	100	96.4
Above 65	0	100	0	0.0	0.0
TOTAL	63.6	94.0	95.3	93.9	97.5

For questions 4 and 5, more than 92% of teachers do not believe that a person can get HIV from mosquito bites and sharing a meal with someone who is infected. All teachers aged 56-65 believe that a person cannot get HIV from mosquito bites which suggests that this particular misconceptions about HIV transmission does not prevail among older teachers.

Table 6.27d shows that indicators for question 1 (which shows correlates the level at which a respondent teaches and the believe that HIV transmission can be reduced by having sex with

one faithful partner) are 69.6% and 64.8% for teachers at tertiary institutions and primary schools respectively. For teachers who teach at CJSS and SSS, the indicators are less than 60%. Indicators for teachers at primary schools are consistently higher for the rest of the questions, which implies that the level of awareness about HIV transmission and prevention seems to be negatively associated with the level at which a teacher teaches. This corresponds to the fact that at primary school level standard five students are more knowledgeable about HIV transmission even though composite indicators are lower compared to high students at higher level of education.

6.27d Indicators by Level of School At Which Respondents Teach (Percentages)

Age Group	Q1 Indicator	Q2 Indicator	Q3 Indicator	Q4 Indicator	Q5 Indicator
Tertiary	69.6	91.9	91.9	87.4	92.3
SSS	57.1	93.2	94.4	95.7	98.1
CJSS	59.9	94.3	96.5	97.1	97.4
Primary	64.8	93.8	94.7	93.2	97.4
TOTAL	63.6	93.7	94.8	93.7	97.4

For the rest of the questions shows a high awareness level across all age groups, with more than 90% of having no misconceptions about HIV transmission. Overall, the composite knowledge indicators for teachers suggest that the level of awareness about HIV/AIDS is higher but there is need to improve awareness creation at SSS and tertiary institutions. The fact that 50% of teachers at SSS do not believe that the risk of HIV transmission can be reduced by having sex with only one faithful partner need to be addressed.

6.5.3 Teachers' Behaviour in Regard to HIV/AIDS

It is widely asserted that teachers are a high-risk behaviour group and that therefore HIV prevalence among the teaching profession is higher than the adult population. A teacher's behaviour has a significant impact on how he/she imparts knowledge on HIV/AIDS to students. A teacher with high risk behaviour is more likely not to emphasise the risks involved in certain aspects of behaviour in regard to HIV/AIDS. Culturally defined gender roles and stereotypes may also creep in through teachers. For example, prescribed submissive roles for females that are deeply embedded in society constrain girls' active participation in the classroom and result in female teachers reinforcing submissive behaviour

for girls. One of the major tasks of the TCB baseline study was to assess the behaviour of teachers. There was a section of questions pertaining to behaviour in the questionnaire that was administered to teachers. This section discusses findings on those questions.

Majority of teachers have had sex before. Only 4% indicated that they never had sex before. The average age at first sex for teachers is 21 years for males and 18 years for females. The average age is marginally lower for males in rural areas of the country, compared to urban males while for female teachers, there were no differences in the average age at first sex between the urban and the rural areas. Proportion of teachers reporting sex with a non-regular partner is an important indicator for tracking sexual behaviour. Non-regular partners were defined as any sexual partner other than the married spouse. In the present baseline survey, respondents were required to provide information on sex with non-regular partners during a 12-month reference period. Overall, 11.8% males and 2% females reported sex with non-regular partners in a 12-month recall period. The findings show a prevalence of this behaviour among 12.6% for male teachers against 11.4% for rural male teachers. The corresponding prevalence rates in female teachers were 2.3% and 1.8% for urban and rural areas respectively. Overall, among the male teachers reporting non-regular sex, 51.2% reported using condoms during the last sex with their non-regular partners as against 39.8% among female teachers reporting such sex.

6.5.4 Age of Teachers And Its Impact on Behaviour

Age is often associated with extent of knowledge or perceptions about certain issues. In this study, age was associated with attitudes, misconceptions and perceptions about HIV/AIDS. The results for teachers show that age has a generally important effect on casual partnerships. In this study, casual relationships are defined as having multiple sexual partners and indulging in orgy. Table 6.25 below shows that risk of casual sex usually peaks among teachers aged 18 to 25 years and decreases linearly with age. About 36% of teachers aged 25-30 indicated that they had multiple partners in the last 12 months compared to 28% for those aged 25-30, 16% for those aged 35-40, 8% for those aged 40-45, 11% for those aged 45-50 and 2% for those aged 50-55. The trend is also present among old teachers (55-65). The prevalence of casual sex peaks after the age of 55, with 4.5% of teachers aged 55-60 and 20% of those aged 60-65 indulging in casual sex (Table 6.28).

Table 6.28 Age and Sexual Behaviour of Teachers

Teacher Age Group	Multiple Sexual Partners			Orgy or Group Sex		
	No	Yes	Total	No	Yes	Total
18-25	71	41	112	101	11	112
%	63.4	36.6	100.0	90.1	9.9	100.0
25-30	199	81	280	364	9	273
%	71.1	28.9	100.0	96.7	3.3	100.0
30-35	180	35	215	199	10	209
%	83.7	16.3	100.0	95.2	4.8	100.0
35-40	237	41	278	258	13	269
%	85.3	14.8	100.0	95.9	4.1	100.0
40-45	104	10	114	108	3	111
%	91.2	8.8	100.0	97.3	2.7	100.0
45-50	119	16	135	129	8	137
%	88.1	11.8	100.0	94.2	5.8	100.0
50-55	49	1	50	50	0	50
%	98.0	2.0	100.0	100.0	0	100.0
55-60	21	1	22	19	1	20
%	95.5	4.5	100.0	95.0	5.0	100.0
60-65	8	2	10	8	2	10
%	80.0	20.0	100.0	80.0	20.0	100.0

The same pattern is registered with indulging in orgies. About 10% of teachers aged 18-25 indulge in orgies compared to less than 10% for other age groups (Figure 6.54). Younger teachers have significantly higher risk behaviour than middle aged teachers. This behaviour linearly falls with age but builds up at the age of 55. The indulgence in multiple sex partnerships and orgies by older teacher may be explained by the sugar daddy and mummy syndrome that older persons usually develop.

Figure 6.54 Extent of Casual Sex Among Teachers

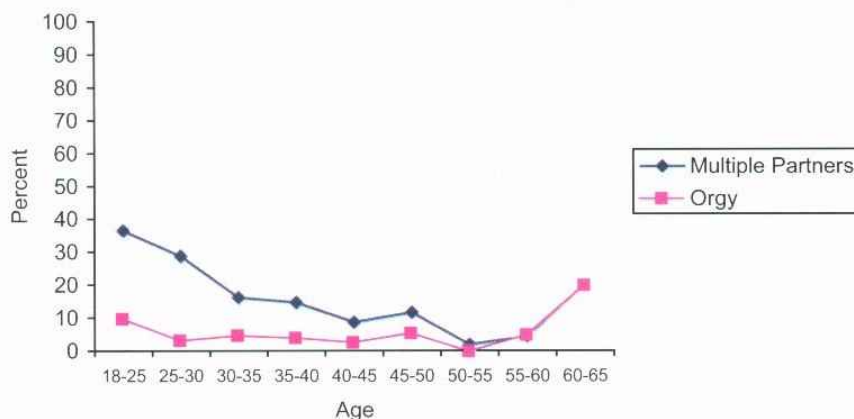


Table 6.26 below shows that casual sex is prevalent among male with age brackets of 18-25 and 25-30 across all education levels. This pattern is present also among primary and CJSS teachers aged 45-65. Casual sex seems to be prevalent among female teachers at primary and CJSS levels in the 30-35 age range and female teachers in the 40-45 age range at SSS and tertiary institutions (Table 6.26). About 69% of female teachers who teach at primary school level and 76% of female teachers who teach at CJSS have multiple partners. The dominance of casual sex among female teachers in this age group may be explained by the fact that it is the prime age for one to get married. Therefore, having multiple partners may increase the chances of getting a serious offer for marriage but at the same time puts female teachers at high risk of being infected with HIV.

Table 6.29 Percentage of Teachers Having Multiple Partners

Age	Primary		CJSS		SSS		Tertiary	
	Female	Male	Female	Male	Female	Male	Female	Male
18-25	8.9	91.1	3.8	96.2	18.2	81.2	21.5	78.5
25-30	14.7	85.3	74.2	25.8	67.6	32.4	57.7	42.3
30-35	69.7	31.3	76.0	24.0	44.1	55.9	39.6	60.4
35-40	43.0	57.0	22.6	77.4	23.5	76.5	15.7	84.3
40-45	36.2	63.8	34.5	65.5	44.1	55.9	37.6	62.4
45-50	12.0	88.0	9.1	90.9	64.7	35.3	77.3	22.7
50-55	46.3	53.7	4.5	95.5	52.9	47.1	63.3	36.7
55-60	13.9	84.1	3.6	96.4	50.0	50.0	57.9	42.1
60-65	10.0	90.0	2.1	97.9	20.6	79.4	23.8	76.2

The results show that older male teachers' behaviour has great potential spreading HIV/AIDS epidemic. Older teachers themselves might be infected and will in turn infect these multiple sexual partners. A large percentage of male teachers aged 60-65 reported having multiple partners in the last 12 months. At primary school level, 90% of male teachers aged 60-65 reported having had multiple sex partners compared to 97% of male teachers at CJSS, 79% of male teachers at SSS and 76% of male teachers at tertiary level (Table 6.29). The high level of knowledge on HIV/AIDS seems to have not translated to changes in behaviour and attitude among male teachers across education.

To further assess the relationship between age and sexual behaviour, teachers were asked several questions relating to this aspect. The results in Table 6.29 show that generally most teachers do not have partners who are least 10 years younger or older. About 70% of the teachers indicated that they have never had a partner who is at least 10 years younger or older while 21% indicated that they have had one partner who is at least ten years younger while the rest have had more than one. On average, primary school teachers have 6 sexual partners that are at least 10 years younger or older while JCSS teachers have on average one sexual partner who is at least 10 years younger or older. As for SSS, on average teachers have at least 3 partners who are at least 10 years younger or older.

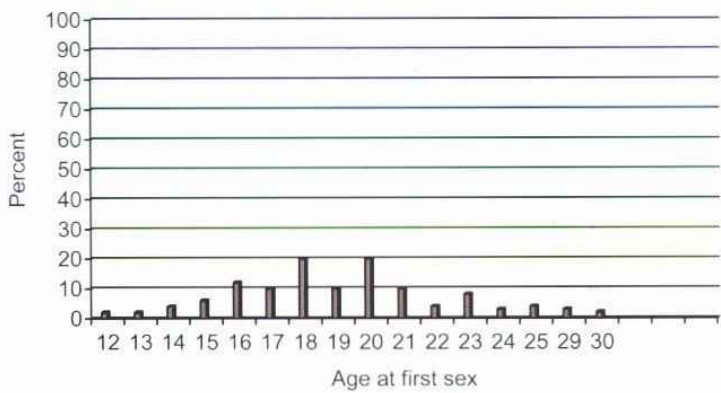
Table 6.30 Ages and Number of Sexual Partners

		Mean	Std. Deviation	Minimum	Maximum
Age of teacher	Male	35.09	8.229	18	64
	Female	33.33	8.300	19	64
Number of partners in last 12 months	Male	6.05	21.164	0	19
	Female	9.10	25.894	0	10
Number of partners at least 10 years or more	Male	7.55	25.831	0	9
	Female	4.40	19.887	0	5
Age of current partner	Male	41.45	17.073	18	65
	Female	36.78	19.313	17	70
Age at first sex	Male	20.99	11.835	7	46
	Female	21.07	13.015	6	35
Current number of partners	Male	6.10	21.418	0	9
	Female	6.15	21.279	0	4

There are no disparities in age distribution of both male and female teachers, with mean age for male teachers being 35 and that of female teachers being 33 years. In terms of number of sexual partners in the last 12 months, female teachers take the lead, on averaging having 9 partners as compared to 6 partners for male teachers. However, the maximum number of sexual partners for male teachers is 19 as compared to 10 for female teachers. Intergenerational sex seems common among male teacher than female teachers. On average male teachers have 7 partners who are at 10 years younger or older compared to 4 for female teachers. This raises concern especially for where people who are possible sexual partners are female students. To what extent do schools in Botswana tolerate sexual harassment and abuse? To what extent is this sexual abuse perpetrated by older male pupils and male teachers. The rapid spread of HIV/AIDS has increased girls' vulnerability to sexual abuse by 'sugar daddies' and by male teachers, relatives and neighbours. In the light of the HIV/AIDS crisis, these issues need to be further explored and addressed.

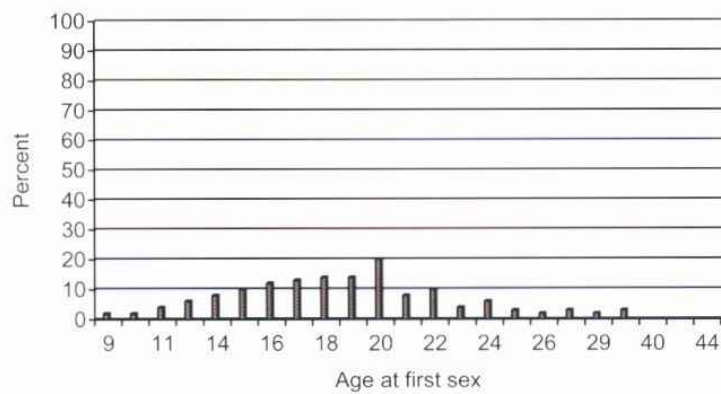
The effects of age on behaviour of teachers was further analysed by assessing age at first sex. There seems to be differences among teachers across all education levels. The modal age at first sex among primary school teachers is 18 years while early age is 12 years. A small percentage of teachers had sex for the first time in their thirties (Figure 6.55).

Figure 6.55 Age at First Sex – Primary School Teachers



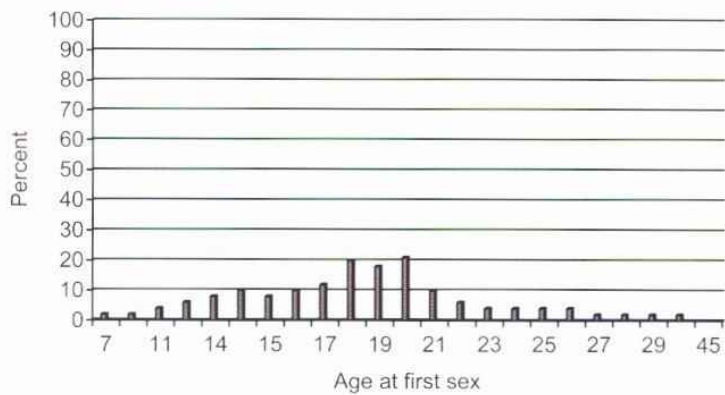
For JCSS, a different picture emerges, with some teachers reporting having had their first sexual encounter as early as the age of 9. The modal age is 20, but there is a concentration of sexual debut in teen years with the oldest sexual debut being 42 years (Figure 6.56)

Figure 6.56 Age at First Sex –CJSS Teachers



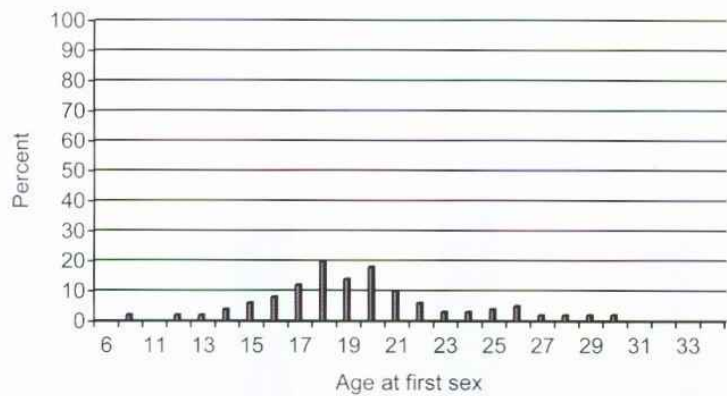
A similar pattern is depicted by the sexual debut of SSS, with majority of them having had sex at ages 18 and 20 (Figure 6.57)

Figure 6.57 Age at First Sex – SSS Teachers



The youngest age of sexual encounter is 14 years and the oldest being 30 years among SSS teachers. This applies to tertiary teachers, who have similar pattern of sexual debut (Figure 6.58)

Figure 6.58 Age at First Sex – Tertiary Teachers

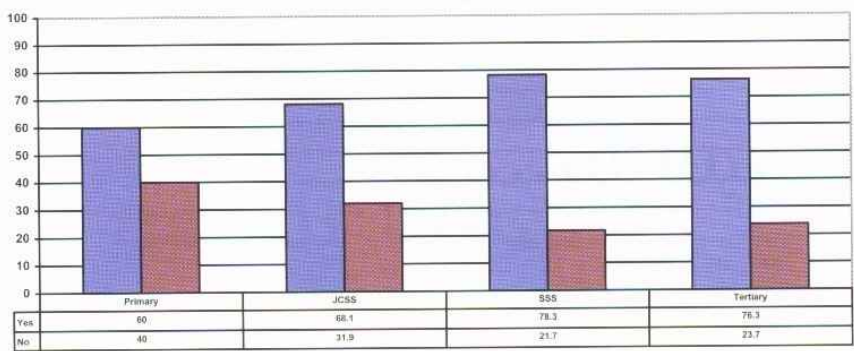


There is not much difference between the current number of sexual partners between male and female teachers. On average both male and female teachers have 6 sexual partners. The maximum number of current partners for male teachers is 9 compared to 4 for female teachers (Table 6.30). This implies that the risk of male teachers spreading HIV is higher than that of female teachers.

6.4.5 Condom Use

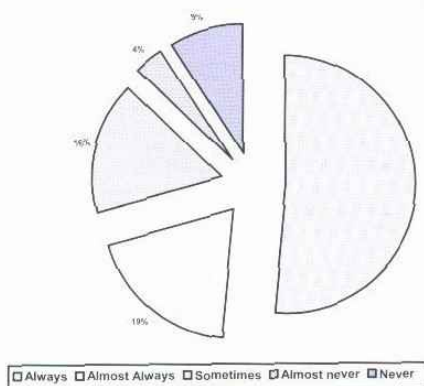
Regarding the benefit of consistent and correct condom use in prevention of transmission of more than half the teachers (63%) were aware that having one faithful and uninfected sex partner could prevent transmission of HIV/AIDS. Teachers in urban areas (both male and female) had better awareness of this aspect compared to rural respondents. A significantly larger proportion of teachers (76%) were aware that sexual abstinence played an important role in prevention of transmission of HIV/AIDS, compared to the other modes of prevention of transmission through the sexual route. About 72% of those who have had sex before indicated that they have consistently used a condom in the last 12 month. A follow up question on whether those who have sex before used a condom consistently during the last 12 months, more than half of the teachers used a condom all the time. According to Figure 6.59, more primary school teachers have risky behavior than the rest of the teachers. Among primary school teachers, 40% reported that they did not use condoms in the last 12 months compared with teachers in teachers in other levels of education. Does this mean that primary school teachers are less aware of the risks of HIV?

Figure 6.59 Condom Usage Among Teachers



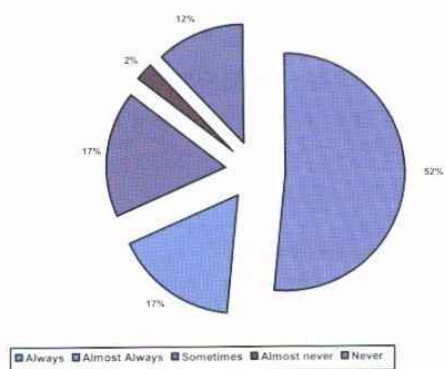
Only 43% indicated that they used a condom at first sex while 3.1% indicated that they had sex with someone else other than the regular partner. A follow up question on whether the respondent has had multiple partners in the last 12 months reveal that 72% of the teachers have had multiple partners and of these 12% teach at primary, 23% teach at JCSS, 22% teach at SSS while 15% teach at tertiary level. Having orgies seems common among teacher at SSS and tertiary. No teacher reported having had orgy at primary school and JCSS, but 7% and 4.8% of SSS and tertiary respectively.

Figure 6.60 How Often Did You or Your Partner Use a Condom



A follow up question on whether the respondent used a condom with the person he/she cheated with shows there is prevalence of risky behaviour. Only 51.7% indicated that they always used a condom while 12% said they did not use a condom. Another question relating to having sex with someone that the respondent knew that is HIV positive revealed a small percentage of teachers do have sex with people whom they know are HIV positive. Across all teachers, 4.3% did indicate that they had sex in the past 12 months with someone they knew was HIV positive. Although this percentage is small, it is indicative of the risky behaviour of some teachers. A follow up question on those who indicated that they have knowingly had sex with an HIV positive partner was often they used a condom. The results show that more than 50% of those who knowingly had sex with an HIV positive person always used a condom while shockingly 17% never used a condom (Figure 6.59).

Figure 6.61 Condom Use With an HIV Positive Partner



Teachers were asked the number of sexual partners in the last 12 months, and this ranged from 0 to 15 with majority of teachers (70.7%) having had one sexual partner in the last 12 months.

A third of the teachers have never successfully refused sex without a condom. Figure 6.60 shows that almost 30% of primary school teachers did not successfully refuse sex without a condom in past 12 months. This risky behaviour is prevalent across teachers in other levels of education.

Figure 6.62 Percentage of Teachers Who Successfully Refused Sex Without a Condom



6.5.5 Multiple Partners

Studies have shown that the greater the number of sexual partners one has, the greater the probability of having sex with an infected partner and, as a result, of becoming infected with HIV. On average teachers have 7 sexual partners (Table 6.31). The maximum number of sexual partners is 17 and the minimum is zero.

Table 6.31 Number of Sexual Partners in the Past 12 Months

Number of Sexual Partners	Frequency	Percent
0	94	5.4
1	1161	67.1
2	148	8.5
3	64	3.7
4	31	1.8
5	16	.9
6	8	.5
7	4	.2
8	5	.3
10	11	.6
11	1	.1
12	3	.2
14	1	.1
15	1	.1
16	95	5.5
17	88	5.1
Total	1731	100

Majority of teachers (67%) have one sexual partner, followed by those who have up to 2 partners (8.5%), those who have had 16 sexual partners and those who have had no sexual partners. It is commendable that there teachers who have chosen to abstain from sex (5.4%). This shows that some teachers teach what they practise. Although the percentages for multiple sexual partners are small, it is alarming that there some teachers who have up to 17 partners in a year (5.1%). This may be influenced by societal acceptance of multiple sex

partners as an expression of male sexuality and masculinity, which ultimately limits behaviour change.

6.5. 5 Intergenerational Sex

Intergenerational sexual relationships, which are largely fuelled by poverty and economic powerlessness, are highly implicated in HIV transmission. Botswana is no exception, and it is generally believed that highly successful older men entice young girls with expensive gifts into having sex with them. The other prevailing mirth is that having sex with a virgin cleanses one of HIV infection. The study assessed to what extent these beliefs exist among teachers. The results show that on average teachers have 7 partners who are who are 10 years younger or older. The modal number of sexual partners who are 10 years younger or older is zero. According to Table 6.31a, 67% of teachers do not engage in intergenerational sex.

Table 6.31a Number of Partners Who are at Least 10 Years younger or More

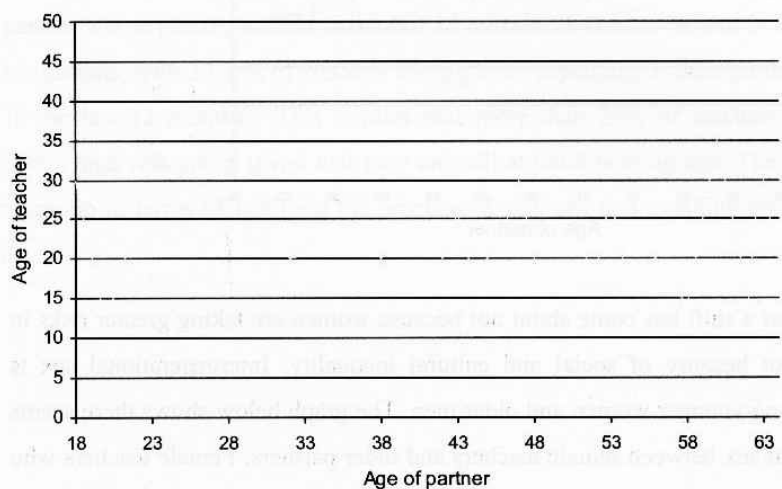
Number of Partners Who are at Least 10 Years younger or More	Frequency	Percent
0	1163	67.2
1	365	21.1
2	7	.4
3	2	.1
9	105	6.1
10	89	5.1
Total	1731	100.0

There are teachers who have up to 10 sexual partners who are 10 years younger or older (5.1%). This may be driven by the mirth that having sex with a virgin may cleans one of HIV infection. Therefore, the younger the sexual partner one has, the more chance of being cleansed from HIV infection. There is still controversy over whether this mirth may not lead to sexual assaults against children. There is a need to prove the link between the myth and child rape. Probably one of the reasons reason for the prevalence of the mirth HIV cleansing with through sex with a virgin is a lack of treatment for the disease.

The graph below shows that intergenerational sex encounters takes place between 18 and 30 years and also between 35 and 64 years. Intra-generational sex among teachers takes places between 25-45 years (Figure 6.63).

Intergenerational sex seems more common at tertiary institutions whereby teachers on average have 9 partners who are 10 years younger or older. The age range for teachers is 18-61 years while for sexual partners is 17 - 65 years (Figure 6.63).

Figure 6.63 Age of Teacher and Age of Sexual Partner



Male teachers' sexual behaviour may be rooted in the cultures they grow up in. Boys grow up believing that it is natural for men to have frequent sex and that having many sexual partners is a sign of virility. Masculinity can be a burden to many men as they find it difficult to live up to the expectations of others. This may explain the fact that there seems to be prevalence of intergenerational sex among male teachers around the age of 30 and from the age of 45 where there may be pressure to prove sexual virility. The explosion of intergenerational sex around the age of 60 is may be explained by the sugar daddy and mummy syndrome as well as the pressure to prove that one is still sexually active (Figure 6.64). Male teachers in their twenties have sexual relationships with partners who are in the sixties and seventies. The possible conclusion is if a twenty year old male teacher is heterosexual and is having a relationship with a partner of age 60 or 70, then sexual partner may be a sugar mommy given the huge age gap.

Figure 6.64 Intergenerational Sex Among Male Teachers

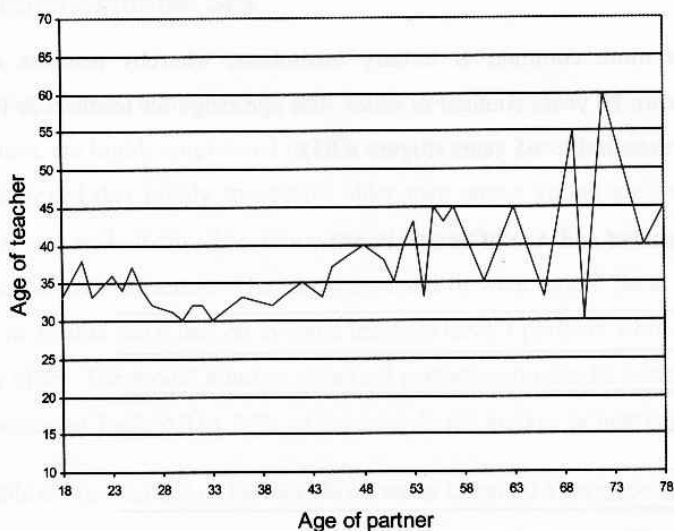
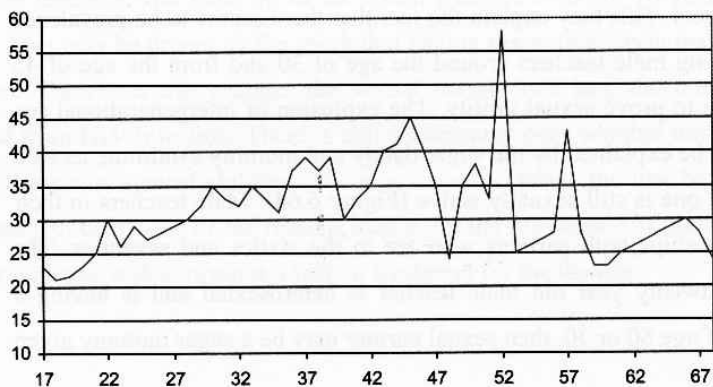


Figure 6.65 shows that a shift has come about not because women are taking greater risks in their sexual lives, but because of social and cultural inequality. Intergenerational sex is usually common among younger women and older men. The graph below shows there seems to be intergenerational sex between female teachers and older partners. Female teachers who are in their twenties have sexual partners who are in the forties and sixties (Figure 6.65).

Figure 6.65 Intergenerational Sex Among Female Teachers



The problem of intergenerational sex does not seem to be a problem of female teachers having older sexual partners, but also of younger teachers having older sexual partners. If intergenerational sex drives the spread of HIV/AIDS, then the results on teachers shows that there is a bigger problem ahead for GOB to curb the spread of HIV infection through this mode of transmission.

Overall a third of the teachers have either expected or their partners have expected a child in the last 12 months. At primary school level, 25% of teachers expecting of their partner was expecting a child in last 12 months. At JCSS, 30.1% of teachers expected or their partner was expecting a child in the last 12 months while 25.8% of teachers at SSS were either expecting or their partner was expecting a child in the last 12 months. A similar pattern is depicted with tertiary institutions, with 30.3 % of students having been expecting or their partner expecting a child in the last 12 months. This implies that more than 25% of teachers and tertiary students are a high risk group given that they are still at child bearing age. The TCB should target this group in terms of instilling the practice of safe sex and avoiding the risk of HIV infection.

6.4.6 HIV/AIDS Screening and Testing for Teachers

On average, a quarter of teachers have requested or undergone HIV testing in the past 12 months. Request for testing or undergoing testing is as per Table 6. 32.

Table 6.32 Have You Requested or Undergone HIV Testing in the Past 12 Months?

Primary		JCSS		SSS		Tertiary	
Yes	No	Yes	No	Yes	No	Yes	No
29.3%	70.7%	24.4	75.6%	25.3%	74.7%	24.5%	75.5%

No teacher reported having had sex with someone who injected or shot drugs in the 12 months. A follow up question on whether teachers use needles to inject and shoot street drugs, steroid or vitamins in the past 12 months also drew a blank. This implies that the spread of HIV is though drug abuse is minimal if not non-existent among teachers.

A small percentage of teachers indicated that a nurse or doctor told them that they had a sexually transmitted disease (STD) other HIV. Among primary school teachers 6% indicated that they were told they had STDs compared to 3.8% of teachers at JCSS. The figures are higher for SSS and tertiary, with 8.6% and 7.45 of teachers respectively having been told they have STDs. Does this mean the prevalence rate of HIV is similar to STD rate? This needs further investigation. SSS and tertiary institutions have an ethical and intellectual responsibility to set an example by having lower rates of incidence of STDs and HIV/AIDS. They constitute one of the essential components in developing a united and effective response to the HIV/AIDS pandemic so the high incidence rate of STDs among teachers at this level is worrying.

It is apparent that there are mixed feelings about testing for HIV. There are those who are for testing and those who are not. In Botswana testing for HIV is voluntary, confidential and it includes counselling. Reasons for testing not testing vary across a wide spectrum of people. Teachers were asked to indicate reasons why they would and would not test for HIV. Table 6.18 below presents the percentage of teachers who voted for different reasons why they would test or not test for HIV.

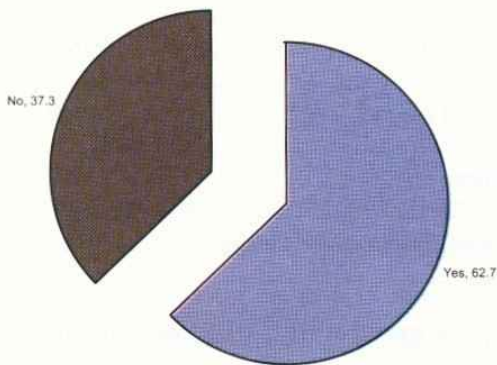
Table 6.33 Reasons for Getting HIV/AIDS Test and for Not Getting Tested for HIV/AIDS

Reasons for Getting HIV/AIDS Test	%	Reasons for Not Getting HIV/AIDS test	%
Marriage	54.8	Lose job	12.6
Family Planning	46.9	Lose terminal benefits	13.1
Insurance	35.7	Lose pension	13.5
Plan for the future	68.1	Lose partner	16.9
Protect Partner	65.9	Fear of knowing	29.6
Protect unborn child	51.1	Stigma	40.6
If I'm sick	24.1	Avoid Frustration and Suicide	48.0

The results show that teachers are concerned about the spread of HIV/AIDS, and hence their positive views about HIV/AIDS testing. Planning for the future and to protect a partner registered 68% and 65% respectively as reasons why teachers would voluntarily test for HIV/AIDS. Marriage is ranked high (54%) followed by protection of unborn children from the risk of having HIV/AIDS transmitted to them (Table 6.33). These results do not reflect the extent to which teachers are willing to undergo HIV/AIDS testing. A follow up question on while there unwillingness to test for HIV/AIDS revealed that avoiding frustration which can lead to suicide (48%) and stigma (40%) were the most commonly cited reasons why people are not willing to undergo HIV/AIDS testing.

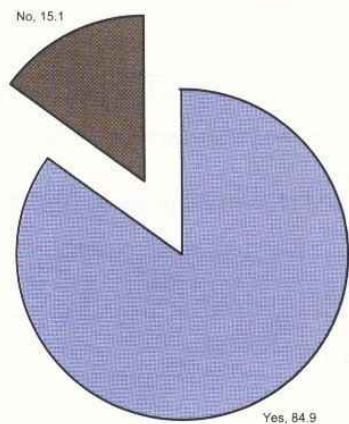
Teachers were asked if they would talk to a partner or parents before having an HIV/AIDS test. A small percentage (37%) indicated that they would talk to a partner or parents (Figure 6.66).

Figure 6.66 Talk to Partner or Parents Before Testing for HIV



A follow up question on whether they would tell anyone the results of an HIV/AIDS revealed that almost 85% of the teachers would share the results of their HIV/AIDS test. It is impressive that a large percentage of teachers indicated that they would share the results of their HI/AIDS test. The stigma associated with HIV/AIDS that those who learn they have HIV are often rejected by their family and friends seems to driving the spread of HIV. Most people fear this and deny their condition.

Figure 6.67 Talk to Partner or Parents Before Testing for HIV



Still 29% of the teachers do not test wrongly believing that ignorance is bliss. This shows that shame is robbing Batswana their lifeline and its future. What do we need to do to survive this epidemic? We need to shatter the stigma associated with HIV. We need to destroy the ignorance that has allowed HIV to grow uncontrollably in Botswana. We need to become educated about HIV/AIDS, and teachers are the first to educate about it so that they can educate the students, who are the future generation of the country.

Table 6.34 shows that the interviewed teachers would rather confide in their partners (74%) and friends (58%) than in parents (33%) or priest (44%). Priests continue to blame those who are infected for being immoral and sinners. It is sad that some of our churches take this view. It is obvious that if the society in general does not become educated about this disease, if Batswana do not drag AIDS out of the shadows where it has been able to fester and grow, then there is serious challenge ahead.

Table 6.34 Persons Comfortable to Tell the Results of HIV Test

Person to Confide in	Percent
Parents	33.2
Partner	74.2
Friend	58.0
Priest	44.8
Fellow Teacher	46.0

There is need to stop treating those with HIV/AIDS as though they are lepers, and for parents to give support, love and respect that all who have a chronic disease deserve.

Teachers were asked if those who are antiretroviral medication are regularly taking the treatment given their work schedule. A total of 19 teachers indicated that they are on antiretroviral medication (Table 6.34). A large percentage of them (68%) indicated that they take their medication regularly while 5% indicated that they take less than 40-60% of the medication.

Table 6.35 The Regularity in Taking Antiretroviral Medication

	Frequency	Percent
Never Missed a pill (100%)	13	68.4
Almost all the time (80-95%)	2	10.5
Usually (60-80%)	3	15.8
About half the time (40-60%)	1	5.3
Sometimes (20-40%)	0	0
Very little time (<20%)	0	0
Total	19	100.0

A follow up question whether the teaching schedule allow for taking of the antiretroviral medication as prescribed, 100% of those teachers who the therapy indicated that the schedule there is no problem. It is not clear why there some teachers who are not taking 100% of the doses. There is need to investigate this further.

The breakdown of teachers who are on antiretroviral treatment shows that majority of them teach at primary school level. Table 6.36 below shows that 14 out 19 teachers who are on antiretroviral medication are at primary school level.

Table 6.36 Regularity in Taking Antiretroviral Medication Per Education Level

		Tertiary	SSS	CJSS	Primary	Total
100%	Count	2	2	0	9	13
	%	15.4%	15.4%	.0%	69.2%	100.0%
>95%	Count	0	0	0	2	2
	%	.0%	.0%	.0%	100.0%	100.0%
80-95%	Count	0	0	0	3	3
	%	.0%	.0%	.0%	100.0%	100.0%
40-60%	Count	0	0	1	0	1
	%	.0%	.0%	100.0%	.0%	100.0%
Total	Count	2	2	1	14	19
	%	10.5	10.5	5.3	73.7	100

Out of those who take 100% of the medication, 69% are primary school teachers while 15.4% are tertiary teachers and the remaining 15.4% are SSS teachers. Those who are taking <95% of medication, all of them are primary school teachers. The same applies to those who are taking 80-95% of the medication, all them teach at primary school level. CJSS teachers are the only ones who take 40-60% of the medication. The high rate of HIV/AIDS infection at primary school is also associated with high rate of default in taking antiretroviral medication. There is need to investigate why this is the case.

6.5.7 Absence From Work

The absence of only one teacher, for even short periods of time, impacts on a large number of children. With up to 20-48 % of teachers reported having never been absent from school due to illness in past 12 months. At primary school level, 38.8% have never been on medical leave in the past 12 months compared to 48.8% of teachers at JCSS who were not on medical leave. Moving up the education ladder, only 20.7% of SSS teachers were not on medical leave during the past 12 months and this is similar to 27.7% of teachers at tertiary level who were not on absent from work due to illness in past 12 months. For those who were absent from work due to illness, at primary school level, teachers were absent for 1-34 days,

at JCSS 1-30 days, at SSS 1-90 days while at tertiary teachers were absent for 1-62 days. This is worrying because long periods may have major effects on the quality of education. Even if all the affected teachers could be replaced (which is improbable), the reducing service experience of the teaching force impact on quality.

6.5.8 Interactive Learning

The findings in the previous section show that HIV/AIDS education is greatly needed among teachers and students in Botswana schools. Schools are a key location for HIV prevention efforts because they provide a means of reaching large numbers of young people. Learning from the experience of Brazil, HIV/AIDS information can be effectively taught through interactive learning techniques. By interactive learning it is meant here any form of learning which occurs as students interact with each other (with or without the teacher) in processing information and exploring ideas. More specifically, it includes the following features:

- It takes place through the purposeful exchange and/or confrontation of ideas, information and opinions.
- It may occur amongst groups of students or it may also involve the teacher.
- All participants in the interaction enjoy equal rights to contribute to it.

This baseline study assessed the extent of interactive learning in schools at different education levels and also explored factors affecting learning performance also have its importance. Because this approach depends on interaction and because this interaction depends in turn on the active engagement of the students, it is essential that the study explore the factors that hinder students' involvement in interaction and what factors support it. These two issues are the subject of this section, and the results are presented below.

6.5.8.1 Factors that Hinder Students’ Involvement in Interactive Learning

In section 6.4, students stated the desire to be more involved in their learning. It is not clear what factors often prevent this from happening? This question put across to teachers in the self-administered questionnaire. Table 6.37 gives the teachers’ views as to the most common factors which hinder their involvement in interactive learning.

Table 6.37 Factors that Hinder Interactive Learning

<i>Factor</i>	<i>Percent</i>
Tiredness	23.8
Fear of being wrong	57.3
Insufficient interest in the class	38.4
Insufficient knowledge about the subject	60.9
Shyness	21.5
Insufficient time to formulate ideas	51.1

Insufficient knowledge about the subject (60%) and fear of being wrong (57%) were mostly chosen factors that hinder students’ involvement in interactive learning. Teachers also indicated that tiredness may contribute to lack of involvement in interactive learning. Among the teachers 23% said this could be true. This is difficult issue since it cannot be controlled by the teacher, except of course that it may be compensated for by other factors such as interesting subject matter. There is need to try and overcome factors by the teachers through the atmosphere that the teacher creates the way in which he/she manages the interaction al students.

6.5.3.2 Factors that Support Students’ Involvement in Interactive Learning

The baseline study also assessed the factors that support students in their desire to be actively involved. Teachers were asked to evaluate the strategies that they use. The results are shown in Table 6.35. The results below show what percentage of scores each factor received. Ranking them in order of importance, giving questions to students to discuss in groups in

order to formulate a group answer was the most popular (60%), followed by allowing students to form groups with friends (59%) and giving a lot of encouraging responses when students speak and participate (57%). Giving a lot of encouraging responses when students speak and participate and making sure that students are well disciplined were ranked the least (Table 6.38)

Table 6.38 Factors that Support Students' Involvement in Interactive Learning

Factor	Percent	Rank
Create an informal atmosphere in the classroom.	24.6	7
Give a lot of encouraging responses when students speak and participate.	57.3	3
Ask questions on topics which students have some knowledge / interested in.	38.4	6
Make explicit that students are encouraged to speak in class.	48.8	5
Allow students to form groups with friends.	59.0	2
Give questions for students to discuss in groups in order to formulate a group answer.	60.9	1
Avoid questions that are too easy or difficult.	21.5	8
Give students a topic to discuss in advance.	51.1	4
Ensure good teacher contentment	2.7	9
Ensure students are well disciplined	2.1	10

The teachers' responses in Table 6.37 and Table 6.38 can be converted directly into a strategy for conducting different forms of interactive learning. This can be done by promoting the systems are seems to be popular with both students and teachers as well as encouraging those that seem to be less popular. These interactive teaching methods reflect what teachers already know from teacher training colleges, and they can be augmented by modifications based on observations made in the classroom as well as new methods.

To establish if teachers have proper equipment for interactive learning, the teachers were asked to list the teaching or learning equipment they often use when conducting lessons. The response to this question was very poor. A lot of teachers left it blank. For the few who

answered the question, the results are presented in Table 6.39 below. These results should be interpreted with caution given that most teachers did not respond to the question.

Table 6.39 Teaching/Learning Equipment Used in Classroom

Equipment	Number	Minimum	Maximum	Sum	Mean	Std. Deviation
Charts	183	0	100	491	2.68	11.44
Radio	198	0	84	734	3.71	11.46
TV/Video	184	0	20	231	1.26	2.46
Text books	168	0	5	50	.30	.71
Board	168	0	5	65	.39	.93
Clay/Wood	182	0	120	326	1.79	12.53

According to Table 6.39, the most popular teaching aid is radio followed by TV/video and clay or wood. Table 6.40 below shows the cross tabulations of teaching equipment with level of education. The use of charts is most popular among primary school teachers. About 85% of teachers who indicated the use charts are at primary school whereas 9.2% of teachers are at CJSS, 3.1% of teachers are at SSS and 2.3% of teachers are at tertiary institutions (Table 6.40)

Table 6.40 Level of Education and Teaching Aid or Equipment

Level of Education	Teaching/Learning Aid					
	Charts	Radio	TV/Video	Textbooks	Board	Clay/Wood
Primary	85.4	84.6	60.0	50.0	100.0	50.0
CJSS	9.2	3.8	25.0	15.0	.0	25.0
SSS	3.1	11.5	10.0	30.0	.0	25.0
Tertiary	2.3	.0	5.0	5.0	.0	.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

A similar pattern is present with respect to radio, TV/Video textbooks and boards, with more than 50% of teachers who indicated that they use these are at primary school level. These results show that primary school teachers seem to use more teaching aids than teachers in other levels of education.

A follow up question was asked to find out the factors that hinder teachers' implementation of interactive learning. Table 6.41 below shows that 28% of the teachers believe there is limited time allocated to teaching to implement interactive learning. Teachers also indicated

that there are limited teaching materials (25%) to implement interactive learning. A small percentage of teachers (1.5%) indicated that there is lack of interest in implementing interactive learning.

Table 6.41 Factors that Hinder Teachers' Implementation of Interactive Learning

Factors that Hinder Interactive Learning	%	Factors that Support Interactive Learning	%
Time allocation	28.6	Group work	13.7
Classroom space	18.4	Assistance from HIV/AIDS coordinator	9.4
Inadequate teaching materials	25.9	Adequate teaching materials	13.2
Lack of knowledge by teachers	10.0	Small number of students per class	29.5
Lack of support by administration	16.6	Support from parents and stakeholders	9.1
Lack of interest by teachers	1.5	Indoor teaching	8.8
		Co-operation between teacher and students	1.5
		Incentives for teachers	14.8
Total	100.0		100.0

How could these limitations be addressed? Teachers came up with suggestion that can improve the implementation of interactive learning. The most popular is small number of students per class (29%), followed by incentives for teachers (14%), group work and adequate teaching materials (13% for each). Teachers also indicated that support from parents and other stakeholders could assist in implementation of interactive learning.

From the previous discussion, we established that except for primary school teachers, most of the teachers do not use much radio or television/video equipment as teaching aid. The base line study further assessed how often teachers use the different types of interactive learning methods. Table 6.40 below shows that 48% of the teachers indicated that they always use

teacher demonstration method, followed by brainstorming or circle knowledge (22%) and individual diagnosis and prescription. The methods that are commonly never used by teachers are whole class lessons (23%), creative activities with student options (19%), objectives, varied for individuals (17%) and class discussions (17%) Table 6.42.

Table 6.42 Methods of Interactive Learning Normally Used

	Never	Rarely	Occasionally	Frequently	Always	Total
Whole class lessons	23.2	15.0	28.4	17.9	15.5	100.0
Programmed materials	6.4	6.4	45.0	23.9	18.2	100.0
Role playing or simulations	8.8	6.2	33.2	32.5	19.2	100.0
Brainstorming or circle of knowledge	13.1	12.5	32.1	20.2	22.0	100.0
Students design their own learning	10.0	5.8	44.2	26.3	13.8	100.0
Small group assignment	0.0	30.8	38.5	23.1	7.7	100.0
Creative activities with students options	19.4	19.4	33.3	22.2	5.6	100.0
Objectives, varied for individuals	17.7	11.5	37.5	24.0	9.4	100.0
Class discussions	17.0	14.2	38.2	23.6	7.1	100.0
Teacher demonstration	2.6	8.0	19.7	21.4	48.3	100.0
Lecture	8.5	18.4	32.4	28.6	12.1	100.0
Media	10.1	28.2	36.2	18.5	7.0	100.0
Individual diagnosis and prescription	5.2	14.4	28.5	31.0	20.9	100.0
Small group work	6.3	11.8	30.2	33.1	18.6	100.0

Only 7% of the teachers indicated that they always use media and class discussions. This has serious implications to the implementation of TCB project, which employs information technology. Both teachers and students should be familiar with or even used to discussions as well as use of media for the TCB project to work. Most of the interactive methods are commonly occasionally or frequently used. The foregoing discussion shows that more needs to be done in promoting the TCB project. There is need to use radio and TV and printed materials (notebooks and calendars) to reach students and teachers. This may improve

increased awareness of the issues surrounding AIDS, increased sexual abstinence and mutual fidelity, and increased condom use.

7.0 CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

The administration of the questionnaire met with serious challenges of language. A good number of primary students had problems of limited understanding of English. As a result, not all questionnaires were self-administered. There are instances where personal interview strategy had to be applied. Almost 96% of the questionnaires were self-administered, 3.8% were assisted self-administered while 0.2% were personal interviews. Researchers also collected demographic data, including respondent's age, gender, race/ethnicity, year in school, and sexual orientation. Females are among majority of those who filled the questionnaire with 51.6% being female students compared to 48.4% being male students. The same pattern is registered among teachers where 68.2% of the teachers were female while 31.8% were male.

The baseline data reveals a complex picture of attitudes and behaviour among students. The results show that 15.3% of the primary school students in selected schools are sexually active. This percentage increases with age, with 8.4% of the standard 5 students having had sex before compared to 14.7% for standard 6 and 18.6% for standard 7 students. For secondary school students, more than 30% of students have had sex before with 34.2% of junior secondary school students have had sex before. For senior secondary schools 55% of the students are sexually active while for tertiary institutions 92.5% are sexually active. By the age of 19, females (80%) are more sexually active than males (67%). High rate of sexual activity has been attributed to culture, monetary reasons and opportunities for sexual intercourse during social events. At least 80% of female students versus 67% male students have had 3 or more sexual partners. Most youths find out about sex from their friends followed by teachers and lastly from parents (see Section 6.3)

Knowledge of HIV/AIDS among youths in selected schools is good, however less than 20% could say the signs and symptoms of HIV/AIDS. However, 85% of study population knew the risk factors of HIV/AIDS transmission. Females were more knowledgeable on HIV/AIDS than the males. These figures change with respect to seeking treatment, whereby 50% of males said they'd seek treatment from traditional healers while only 80% of females said they would seek it from health institutions.

Knowledge on condoms was high in both males and female although only 50% of males and 40% females that are sexually active used them. Constraints in use of condoms include:

- lack of money
- inadequate or lack of parental, teacher and health staff support
- young girls have sexual partners who are older and therefore not able to be assertive and usually have sex with adults for money
- condoms are too big for most male students, especially those at primary school.

Students feel that by increasing condom use, the risk of contracting HIV/AIDS is being reduced among the youth. However, most primary school students are still at risk because they either occasionally use condoms or never use condoms. The baseline data reveal fairly high levels of condom use among sexually experienced youth in secondary schools. For example, 65 % of selected males and 49 % of selected n females said they used a condom at last sex. Slightly more than half of males and females reported always using a condom during the last six months

Students feel that the primary responsibility for their sexual education and information about the risks of HIV/AIDS is with their parents. Most students cited the primary source of information for HIV/AIDS as mass media, streets, friends, *Kgotla* and schools. Percentage of parents as a source of information was negligible. The students' concern is that when they get sex education and information about HIV/AIDS from the street, they are unequipped to discuss several issues with parents. Therefore, this barrier in communication renders the students more vulnerable to HIV/AIDS infections

Misinformation about HIV/AIDS may contribute to potentially stigmatising attitudes about people living with HIV/AIDS. Although many students agreed that HIV-positive students should be permitted to continue in school, more than a quarter of the students said that students who are suffering from AIDS should not be allowed in class. Female students show more tolerant attitudes toward people with AIDS. Female students were consistently less fearful of infection through casual contact than males. This may imply that more female are more knowledgeable about HIV/AIDS than males. When individuals feel more confident about their HIV/AIDS knowledge they are less likely to fear infection through casual contact

and are more tolerant of people with HIV/AIDS. This indicates that HIV-prevention and intervention programmes must focus on the particular concerns of males and females.

Interestingly, the data suggest little relation between students' perceived susceptibility to HIV/AIDS and attitudes about people living with AIDS. While this might seem disheartening to prevention efforts, a correlation between high tolerance toward people with AIDS and perceived invulnerability would imply that students empathise with people with AIDS only if they feel that HIV/AIDS is something that cannot happen to them. The lack of a correlation, therefore, may actually indicate that students are empathetic toward people with AIDS regardless of their own perceived susceptibility to the disease.

It is apparent that teachers who teach courses on sexuality, HIV/AIDS, and relationship skills clearly need special training to increase their knowledge and comfort levels. During the survey, some teachers expressed discomfort with the idea of demonstrating condom use to students. Some were also concerned that students might know more about condoms than they do and ask difficult questions. Hands-on condom use demonstrations seemed too embarrassing. In addition to intensive training courses, teachers need ongoing support as they teach so that they are able to handle such situations as student embarrassment or parental objections.

Many young people complained about the size of the condom, claiming it is too big. The fact that at young people are attempting to use condoms reflect their interest in protecting themselves and their partners, an essential prerequisite to behaviour change that school-based interventions must address. Some grey areas in relation to awareness levels in HIV/AIDS emerged from the survey and these areas need to be tackled on a priority basis to improve knowledge of teachers. Prospective teachers should receive more specific training related to HIV/AIDS.

Early sexual debut was said to be due to peer pressure among boys and to the perceived benefits of exchanging sex for cash among girls. However, it was believed that intercourse at a young age was associated with an overall weakening of the body and a slowing in physical growth and development among boys. Girls recognised that early pregnancy may be harmful to their health and spoil their career plans. Students knew that condoms prevented HIV/AIDS but were extremely unsure as to how they did so, as most of them had never seen one. In addition, girls' negotiation skills to persuade an unwilling partner to use a condom or to resist

forced intercourse (which was condoned by a number of younger boys) were weak. Most students were in favour of a condom distribution system within the school but also called for the need for a parallel programme for out-of-school youth which could perhaps co-ordinated by young commercial traders with whom they were already familiar. Students wanted to learn about HIV/AIDS in the classroom but said that they would be unable to transmit what they had learnt to their uneducated peers. They claimed the latter perceived them to lack credibility and would not respect their talking to them about sexual matters given their young age.

7.2 Recommendations

While students' knowledge about HIV/AIDS transmission was generally found to be good, their attitudes were not particularly favourable towards those who are infected with HIV. One explanation could be that in our study population, knowledge of HIV/AIDS transmission per se is inadequate or irrelevant to the formation of attitudes favourable towards infected persons. Other items of information might be needed for the formation of more favourable attitudes. These could include recommendations of occupational health experts. In addition, factors like cultural norms, religious values, past experiences and the opinions of parents can exert profound influences upon a student's attitudes such that they may even run contrary to objective facts.

The myth that AIDS can be cured by having sex with a virgin exposes girls as young as six to rape. Gifts, money and promises of marriage lure teenage girls into sexual relationships that put them at risk of HIV infection. Addressing sexual abuse in schools is an important human rights issue and a tool in the fight against HIV infection and AIDS.

The primary aim of the TCBP should be to change students' and teachers' attitudes towards HIV infection. The use of interactive learning would allow students to clarify their doubts and work through personal biases. HIV infected persons should be involved as speakers and facilitators in the TCB projects. By adding a human dimension, they can help to dispel myths and stereotypes. Acquaintance with an HIV/AIDS infected person was also shown in this study to be associated with higher knowledge.

Teacher education programmes should be incorporated into the intervention to aid teachers understanding of policies, as well as minimise misconceptions and future conflicts between infected and uninfected teachers. The TCB activities could be run in tandem to increase students' acceptance of infected teachers.

Skills-based training is recommended for both teachers and students for them to be able to have relevant skills to deal with areas as risk assessment, negotiation, safe sexual practices, abuse, and encouraging the use of abstinence and the use of condoms. An experimental project studied by the University of Zimbabwe found that a skill-based participatory activity was more effective than an information-based intervention in changing HIV/AIDS-related

attitudes and practices (increased knowledge about condoms and their correct use, increased self-efficacy, fewer sexual partners, and fewer coital acts without a condom).

Students affected by HIV/AIDS should be reached before they become orphans. The impact of parental HIV/AIDS situation on students starts when a parent is diagnosed or becomes ill with HIV/AIDS. Students indicated that their education suffer when they stay home from school to do chores and to care for younger siblings and for sick adults.

There is need to address stigmatization of and discrimination against HIV/AIDS-affected teachers and students. Fear of disclosure limits both students and teachers to go forward and test for HIV/AIDS. To reduce the stigma of HIV/AIDS, social service agencies should work to increase the sensitivity of community members, including students, to the needs of HIV/AIDS affected people. This should include communal efforts to monitor and reduce mistreatment of these students, such as teasing, neglect, and physical and sexual abuse. As innocuous as they may seem, teasing and gossip are widespread and painful manifestations of stigma directed at students and teachers affected by HIV/AIDS.

There also need to improve the morale of students affected by HIV/AIDS by keeping them in school and offering sports and recreational activities. This study links schooling to the happiness of both younger and older students. Since parents' illness can cause students to drop out of school, efforts should be made to inform families about the role of consistent schooling in sustaining students' morale through difficult transitions. Sports and recreation are other inexpensive but often overlooked activities that help to integrate children with their peers and maintain psychosocial wellbeing.

Adult-to-child communication should be improved and there is need to provide counselling on such difficult issues as parental illness, parental death, and sex education. Parents and teachers alike articulate a need for support with and advice about discussing difficult issues with students. It is important to respond to this demand because the psychosocial needs of these students are often overlooked on the excuse that there are young.

The challenge for the TCB project is to improve awareness of the consequences of unsafe sexual practices and increase understanding of measures needed to reduce the incidence of

HIV/AIDS amongst identified high risk groups through sample social surveys of potentially higher risk students and progress reports.

The TCBP should increase effectiveness and confidence amongst teachers in delivering safe sex education messages at the school levels and by formal and informal mechanism, measured through surveys of teachers and PTA members. As noted in section 6.4, students felt that parents can play an integral role in the prevention of the spread of HIV. However, many students also stated that parents may shy away from open dialogue about safe sex practices, condom use, or why a young person should refrain from having sex before marriage in an attempt to respect traditions and cultural norms. In order to fully prevent the spread of this fatal disease, there is need to stop pretending and start to realise that sex is practised by young people whether or not they should is not the question, the point is that it is practised. The TCB should educate parents through the PTA otherwise if parents are left out they may not live to see their graduate from school.

There is a need to periodical evaluate satisfaction amongst teachers, students and parents on sex education and other HIV/AIDS awareness programs, measured through monitoring and evaluation surveys. Specifically, the researchers recommend the following

1. Design of participatory approaches and programs for peer discussions amongst students on HIV/AIDS issues and actions.
2. Design of a set of specific HIV/AIDS teaching units and lessons, and integrate them into the curriculum of upper secondary and post tertiary institutions which contain potentially higher risk students.
3. Design of a set of introductory HIV/AIDS lessons, and integrate them into the curriculum of primary and lower secondary schools.
4. Development of a cadre of teaching staff who can effectively deliver HIV/AIDS awareness programs.
5. Development of an effective curriculum or syllabus on sexuality for students
6. Promote student friendly clinics in all health institutions and improve attitude of health staff towards students.

7. Improve the knowledge of teachers and parents on HIV/AIDS
8. Peer education should start from an early age.
9. Peer education should be closely associated with the whole environment and the whole community to enable students to be more assertive with older people.
10. Sex education including HIV prevention should to be part of the school curriculum.
11. Teachers should encourage teachers through PTA to teach sex education to their children to be more comfortable with issues of HIV/AIDS
12. Students should be mobilised to participate and contribute more actively in HIV/AIDS care and prevention programmes.
13. There is need to further address ambiguity towards condoms
14. Reduce class size and make available adequate teaching materials.

8.0 REFERENCES

Avins, A.L.; Lindan, C.P.; Woods, W.J.(1997),Changes in HIV-related behaviors among heterosexual alcoholics following addiction treatment. *Drug and Alcohol Dependence* 44(1):47–55.

Avins, A.L.; Woods, W.J.; Lindan, C.P.(1994), HIV infection and risk behaviors among heterosexuals in alcohol treatment programs. *JAMA* 271(7):515–518

Bennel, Paul; B. Chilisa Karin Hyde; Archie Makgothi; Enni Molobe; Limpet Mpotokwane (2001) *The Impact of HIV/AIDS on Primary and Secondary Education in Botswana: Developing a Comprehensive Strategic Response*. Serial No. 45. Gaborone. Government of Botswana and DFID.

Branco, Cristina Castello and Moanakwena, Penelope G. (2003) *Teacher Capacity Building Project Curriculum for HIV, AIDS and STIs*. Gaborone.

Cook, R.T (1998). Alcohol abuse, alcoholism, and damage to the immune system: A review. *Alcoholism: Clinical and Experimental Research* 22(9):1927–1942.

Government of Botswana (1998) *Botswana National Policy on HIV/AIDS*. Presidential Directive CAB 33/93 dated 23 September 1998. Gaborone. Government Printer.

Government of Botswana (1999) *Education Statistics 1999*. Gaborone. Government Printer.

Government of Botswana (2001) *Botswana in Figures 2001*. Gaborone. Government Printer.

Government of Botswana (2003) *National Development Plan 9: 2003/04 – 2008/09*. Ministry of Finance and Development Planning. Gaborone.

Government of Botswana (2003) *Training of Trainers Course Workshop on Interactive Teaching Methods*. Teacher Capacity Building Project. Gaborone. Dept. of Teacher Training and Development.

Government of Botswana (Undated) Teacher Capacity Building Project for HIV/AIDS Prevention. Project Briefing Notes. Gaborone. MoE, UNDP and ACHAP.

Lucas, G.M.; Gebo, K.A.; Chaisson, R.E.; and Moore, R.D (2002), Longitudinal assessment of the effects of drug and alcohol abuse on HIV-1 treatment outcomes in an urban clinic. *AIDS* 16(5):767-774.

McKirnan, D.J.; Vanable, P.A.; Ostrow, D.G.; and Hope, B (2001) . Expectancies of sexual "escape" and sexual risk among drug and alcohol-involved gay and bisexual men. *Journal of Substance Abuse* 13(1-2):137-154.

Petry, N.M (1999), Alcohol use in HIV patients: What we don't know may hurt us. *International Journal of STD and AIDS* 10(9):561-570.

Purcell, D.W.; Parsons, J.T.; Halkitis, P.N. (2001). Substance use and sexual transmission risk behavior of HIV-positive men who have sex with men. *Journal of Substance Abuse* 13(1-2):185-200.

UNDP (2000) Macro-economic Impacts of HIV/AIDS Epidemic in Botswana. BIDPA. Gaborone

UNDP (2001) Botswana: Towards National Prosperity. Common Country Assessment. Printing and Publishing Company Botswana (Pty) Ltd. Gaborone.

Wagner, J.H.; Justice, A.C.; Chesney, M. (2001), Patient- and provider-reported adherence: Toward a clinically useful approach to measuring antiretroviral adherence. *Journal of Clinical Epidemiology* 54(12 Suppl. 1):S91-S98.

APPENDIX A

PRIMARY SCHOOLS							
SCHOOL	Male Students	Female Students	Male Teachers	Female Teachers	Total of Students	Total of Teachers	No. of students to be interviewed
Ithuteng	460	486		29	946	29	81.0857143
Notwane	558	529	6	32	1087	38	93.1714286
Block 5	516	547		30	1063	30	91.1142857
							0
Mogobane	203	171	3	14	374	17	32.0571429
Mafitlhakgosi	329	357	4	22	686	26	58.8
							0
Kgabotshwene	73	88	2	7	161	9	13.8
Ramotlabaki	41	49	1	7	90	8	7.71428571
Rasesa	267	251	6	13	518	19	44.4
Khurutshe	44	37	3	5	81	8	6.94285714
							0
Magalatladi	415	449	4	24	864	28	74.0571429
Kumakwane	338	381	3	21	719	24	61.6285714
Thebephatshwa	176	156	1	14	332	15	28.4571429
Sesung	210	209	1	15	419	16	35.9142857
Dutlwe	129	146	4	7	275	11	23.5714286
							0
Sojwe	322	348	4	19	670	23	57.4285714
Makgasane	247	259	5	13	506	18	43.3714286
Lephaleng	317	366	3	21	683	24	58.5428571
Molepolole New	134	113	1	11	247	12	21.1714286
							0
Ramolefhe	179	178	7	8	357	15	30.6
Molapowabojang	332	332	2	21	664	23	56.9142857
Segopotso	372	432	3	21	804	24	68.9142857
Metlobo	115	139	3	9	254	12	21.7714286
Bakga	454	485	5	31	939	36	80.4857143
Ranaka	325	276	4	18	601	22	51.5142857
							0
Maiphitlhwane	302	318	3	19	620	22	53.1428571
Bothakga	397	453	9	27	850	36	72.8571429
Mabutsane	226	219	3	13	445	16	38.1428571
Kgalagadi	271	241	3	15	512	18	43.8857143
Goodhope	150	162	8	7	312	15	26.74285714
Phitshane							
Molopo	187	149	6	10	336	16	28.8
							0
Ukhwi	57	37	4	3	94	7	8.05714286

PRIMARY SCHOOLS							
SCHOOL	Male Students	Female Students	Male Teachers	Female Teachers	Total of Students	Total of Teachers	No. of students to be interviewed
Mosiwa	251	212	3	13	463	16	39.6857143
Seetelo	187	153	1	17	340	18	29.1428571
Middlepits	60	72	4	6	132	10	11.3142857
							0
							0
Nojane	194	173	5	10	367	15	31.4571429
Kgapamadi	162	133	4	7	295	11	25.2857143
							0
							0
Shashe	185	201	4	13	386	17	33.08571429
Chanoga	80	63	2	6	143	8	12.2571429
							0
Toteng	186	168	5	10	354	15	30.3428571
Sehitwa	311	300	11	11	611	22	52.3714286
Kathiana	196	179	5	7	375	12	32.1428571
Gumare	414	406	6	22	820	28	70.2857143
Kazungula	165	163	3	9	328	12	28.1142857
Parakarungu	144	125	4	7	269	11	23.0571429
							0
Makaleng	153	159	1	12	312	13	26.7428571
Kgari	88	78	2	6	166	8	14.2285714
							0
Matsiloje	196	174	3	14	370	17	31.7142857
Tati Siding	439	457	2	27	896	29	76.8
							0
Mahube	501	528	4	27	1029	31	88.2
Aerodrome	442	406	3	26	848	29	72.6857143
							0
Maphorisa	356	345	2	20	701	22	60.0857143
Nkange	357	337	5	19	694	24	59.4857143
Sepako	144	144	5	8	288	13	24.6857143
Kutamogoree	153	169	3	9	322	12	27.6
Borolong	359	361	2	23	720	25	61.7142857
Madisakwane	556	519	4	33	1075	37	92.1428571
Mokane	457	474	4	26	931	30	79.8
Mosu	331	261	7	14	592	21	50.7428571
							0
Tsetsebye	391	353	5	20	744	25	63.7714286
Lentswelemoruti	57	53	4	4	110	8	9.42857143
							0
Botshabelo	394	408	2	23	802	25	68.7428571
Mogapinyana	218	170	4	12	388	16	33.2571429
Damechujena					0	0	0

SCHOOL	Male Students	Female Students	Male Teachers	Female Teachers	Total of Students	Total of Teachers	No. of students to be interviewed
Paje	299	220	1	22	519	23	44.4857143
Dimajwe	201	194	6	10	395	16	33.8571429
							0
Moiyabana	379	360	5	20	739	25	63.3428571
Mokgware	51	47	2	5	98	7	8.4
Lerala	312	305	4	16	617	20	52.8857143
Ramokgonami	477	424	6	24	901	30	77.2285714
							0
Boipuso	425	357	2	23	782	25	67.0285714
Gootau	151	179	3	11	330	14	28.2857143
							0
Mokibe	475	434	4	24	909	28	77.9142857
Srthlomo	308	312	6	13	620	19	53.1428571
Flowertown	298	301	3	19	599	22	51.3428571
Machaneng	299	284	6	17	583	23	49.9714286
Mookane	144	162	17	12	306	29	26.2285714
SUB-TOTAL	19757	19323	283	1163	39080	1446	3349.71429

APPENDIX B SECONDARY SCHOOLS

SECONDARY SCHOOLS							
SCHOOL	Male Students	Female Students	Male Teachers	Female Teachers	Total of Students	Total of Teachers	No. of students to be interviewed
Motswedi CJSS	323	361	13	25	684	38	136.8
Baratani	154	168	11	11	322	22	64.4
Radikolo	283	310	15	24	593	39	118.6
Lempu	287	355	19	14	642	33	128.4
Kgari Sechele	723	748	40	41	1471	81	294.2
Mariba	220	241	16	9	461	25	92.2
Kgosimpe	185	143	11	15	328	26	65.6
Tsabong	285	275	24	16	560	40	112
Matsha College	524	650	49	27	1174	76	234.8
Rethuseng	154	158	20	5	312	25	62.4
Gantsi Senior	560	594	49	18	1154	67	230.8
Maun Senior	772	849	65	30	1621	95	324.2
Chobe	384	368	25	13	752	38	150.4
Zwenshambe	331	336	19	12	667	31	133.4
Sua	239	239	16	13	478	29	95.6
Francistown Senior	496	527	44	28	1023	72	204.6
Mopipi	344	364	22	12	708	34	141.6
Gobojango	231	249	18	9	480	27	96
Mothamo	328	442	25	24	770	49	154
Mmaphula	332	398	17	21	730	38	146
Moeng	559	619	54	20	1178	74	235.6
Mookane	144	162	17	12	306	29	61.2
SUB-TOTAL	7858	8556	589	399	16414	988	3282.8
GRAND TOTAL	29550	29721	1195	1858	59271	3053	7439.91429

APPENDIX C TERTIARY

TERTIARY SCHOOLS							
SCHOOL	Male Students	Female Students	Male Teachers	Female Teachers	Total of Students	Total of Teachers	No. of students to be interviewed
Lobatse College of Education	120	187	17	34	307	51	61.4
Tlokwenng College of Education	121	193	11	35	314	46	62.8
Molepolole College of Education	292	305	86	53	597	139	119.4
Tonota College of Education	225	410	96	77	635	173	127
Serowe College of Education	120	181	24	41	301	65	60.2
Francistown College of Education	121	193	11	31	314	42	62.8
Selibe-Phikwe College	529	340	35	10	869	45	173.8
Automotive Training College	417	33	43	15	450	58	90
SUB-TOTAL	1945	1842	323	296	3787	619	757.4

APPENDIX D STUDENT SUMMARIES

KNOWLEDGE

	PRIMARY			CJSS			SENIOR			TERTIARY		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Is there anything that one can do to avoid getting the virus?												
Yes	73.8	76.8		84.3	85.6		97.8	99.4		98.3	95.0	
No	26.2	23.2		15.7	14.4		2.2	0.6		1.7	5.0	
Total	100	100		100	100		100	100	100	100	100	100

What can a person do to avoid getting the virus that causes AIDS?

	PRIMARY			CJSS			SENIOR			TERTIARY		
	Male	Female		Male	Female		Male	Female		Male	Female	
Abstain	58.2	62.2		72.7	79.1		89.5	88.8		81.0	79.5	
Use condoms	75.7	74.0		70.8	71.8		76.8	74.2		79.3	73.9	
Limit sex to one partner	37.8	36.8		30.7	33.8		36.6	35.2		35.3	38.5	
Avoid sex with prostitutes	25.8	24.0		19.2	21.3		34.3	29.6		33.6	31.1	
Avoid sex with person with many partners	34.5	35.7		35.4	33.2		42.5	39.8		44.8	41.0	
Avoid homosexuality	21.8	19.9		11.7	8.8		11.4	7.4		16.4	16.8	
Avoid sex with drug taker	22.3	23.7		15.6	14.2		15.1	11.2		20.7	21.7	
Avoid blood transfusion	36.2	38.2		36.0	37.9		47.8	49.2		43.1	46.0	
Avoid kissing								49.4				
Seek	17.1	15.8		9.2	8.9		7.2	8.7		16.4	10.6	

protection from healers												
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Knowledge and Behaviour

	PRIMARY			CJSS			SENIOR			TERTIARY		
	Male	Female		Male	Female		Male	Female		Male	Female	
Have you ever had sex before?												
Yes	16.7	13.2		42.9	26.3		59.5	51.4		94.0	91.9	
No	83.3	86.8		57.1	73.7		40.5	48.6		6.0	8.1	
Total	100	100		100	100		100	100		100	100	
Have you ever had sex with someone 10 years older or more?												
Yes	9.8	9.3		11.1	16.7		9.7	10.8		19.0	15.6	
No	67.7	70.2		60.0	44.4		58.7	80.8		81.0	84.4	
N/A	22.4	20.4		28.9	38.9		2.5	8.4		0.0	0.0	
Total	100	100		100	100		100	100		100	100	
When was the last time you had sex												
Days ago	5.3	3.4		11.3	8.3		7.9	7.6		26.8	24.7	
Weeks ago	3.0	2.3		8.5	4.1		9.5	6.8		25.9	24.0	
Months ago	6.6	7.1		21.9	12.3		40.4	35.7		42.0	42.9	
Total	100	100	100	100	100	100	100	100	100	100	100	100

Information About Condoms

	PRIMARY			CJSS			SENIOR		TERTIARY		
	Male	Female		Male	Female		Male	Female	Male	Female	
Did you use condom at first sex?											
Yes	29.1	33.3		42.1	83.3		62.5	72.5	52.6	64.9	
No	25.4	17.6		18.5	14.8		28.5	8.7	47.4	28.1	
N/A	45.6	49.1		39.5	51.9		9.0	18.8	0.0	7.0	
Total											
Do you ever refuse sex without a condom?											
Always	16.3	13.5		25.5	23.4		28.1	28.1	61.9	56.5	
Sometimes	12.6	13.1		10.3	10.2		21.3	17.8	19.0	25.8	
Never	28.0	28.5		29.4	20.8		43.2	39.4	19.1	16.1	
N/A	43.1	44.9		34.8	45.7		7.4	14.7	0.0	1.6	
Total	100.00	100.00		100.00	100.00		100.00	100.00	100.00	100.00	

Do you know a place where one can get condoms?												
Yes	95.9	95.6		95.0	94.0	94.5	97.3	96.2		100	100	100
No	4.1	4.6		5.	6.0	5.5	2.7	3.8		0.0	0.0	0.0
N/A										0.0	0.0	0.0
Total										100	100	100
Have you ever had problems in getting condoms?												
Yes	13.5	13.5	13.5	22.4	19.3		25.6	18.3		14.0	7.5	
No	86.5	86.5	86.5	77.6	80.7		74.4	81.7		86.0	92.5	
Total	100	100	100	100	100	100	100	100		100	100	100
Main reasons for failing to get condoms:												
Afraid	2.2	1.9		5.4	2.8		6.6	3.4		1.0	0.7	
Shy	1.1	2.4		4.9	6.6		10.9	8.2		5.7	2.6	
Fear paren	1.0	0.6		2.4	1.3		1.1	1.2		1.0	0.0	
N/A	95.7	95.0		87.3	89.2		81.4	87.1		92.4	96.7	
100	100	100	100	100	100	100	100	100		100	100	100

The last time you had sex did you use condom?

	PRIMARY			CJSS			SENIOR			TERTIARY		
	Male	Femal	Total	Male	Femal	Total	Male	Femal	Total	Male	Female	
Yes	12.3	10.1		33.8	22.0		52.0	46.4		81.9	82.4	
No	5.1	3.9		10.5	4.3		7.7	5.7		12.9	10.1	
N/A	82.6	86.0		55.7	73.7		40.4	47.9		5.2	7.5	

What is your relationship to the person with whom you last had sex?

	PRIMARY			CJSS			SENIOR			TERTIARY		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Husband/Boy friend	1.9	4.5		3.7	17.9		3.1	43.9		3.8	79.1	
Wife/Girlfriend	6.0	1.7		29.9	1.6		48.3	1.2		80.2	3.8	
Casual acquaintance	0.7	0.3		1.7	0.3		3.4	1.0		7.5	0.0	
Relative	1.0	0.8		2.0	0.8		1.6	0.4		0.9	0.6	
N/A												
Total												

For how long have you had sexual relationship with this person?

Days ago	3.0	2.5		8.5	5.5		5.9	3.1		6.4	2.5	
Weeks ago	1.5	1.4		4.5	2.5		5.4	2.1		2.7	3.8	
Months ago	2.6	1.7		10.9	5.9		24.0	20.5		38.2	22.8	
Years	4.3	2.5		16.2	6.8		22.8	21.8		46.4	59.5	

Did you agree to have sex?

Yes	6.4	3.6		29.7	11.9		55.0	42.2		90.2	85.4	
No	7.6	7.7		10.8	10.8	10.8	3.8	6.8		3.6	3.2	
N/A	86.0	88.7		59.5	77.2		41.2	51.0		6.3	11.4	

APPENDIX E School Summaries

Number of deaths by School category

	STUDENTS			TEACHERS		
DEATHS	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Primary	19	28	47	12	20	32
CJSS	1	1	2	1	1	2
Senior	5	2	7	3	1	4
Tertiary	-	1	1	-	-	-
TOTAL	25	32	57	16	22	38

Number of deaths in Urban Schools

	URBAN					
	STUDENTS			TEACHERS		
DEATHS	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Primary	3	4	5	2	2	-
CJSS	-	-	-	-	1	1
Senior	-	-	-	-	-	-
Tertiary	-	-	-	-	-	-
TOTAL	3	4	7	2	3	5

Number of deaths in Urban Village Schools

	URBAN VILLAGES					
	STUDENTS			TEACHERS		
DEATHS	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Primary	13	21	34	9	20	29
CJSS	1	1	2	1	-	1
Senior	-	2	2	2	1	3
Tertiary	3	1	4	-	-	-
TOTAL	17	25	42	12	21	33

Number of deaths in Rural Schools

RURAL VILLAGES						
	STUDENTS			TEACHERS		
DEATHS	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Primary	3	2	5	1	1	2
CJSS	-	-	-	-	-	-
Senior	-	-	-	1	-	1
Tertiary	-	-	-	-	-	-
TOTAL	3	2	5	2	1	3

Drop outs Ratios

Total drop out rate is $533/30549=0.02 *100 = 2\%$

Total number of drop outs per School Category

	PRIMARY			CJSS			SENIOR		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Pregnancy	-	13	13	-	21	21	-	4	-
Illness	15	32	47	3	3	6	10	-	10
Social problems	138	139	277	52	53	105	19	-	19
Distance	13	18	31	-	-	-	-	4	-
Total	166	202	368	55	77	132	19	4	33

Drop out rate for different School categories;

Drop out rates for different School Categories

	MALE	FEMALE	TOTAL
Primary	1.04	1.39	1.20
CJSS	1.64	2.08	1.87
Senior School	1.06	0.19	0.56
Tertiary	-	-	-

Total number of students per School Category

	MALE	FEMALE	TOTAL
Primary	15992	14557	30549
CJSS	3356	3694	7050
Senior School	1785	2069	3854
Tertiary	249	242	491

Girl/boy ratio for different School categories;

Girl/boy ratios for different School Categories

	RATIOS
Primary	0.91
CJSS	1.10
Senior School	1.16
Tertiary	0.97

Number of teachers by School category

Categories	Permanent Teachers	Temporary Teachers	Total
Primary	943	100	1043
CJSS	281	40	321
Senior	335	15	350
Tertiary	46	18	64
TOTAL	1605	173	1778

Does the school have a teacher capacity building team

	Frequency	Percent
Yes	37	50.0
No	33	44.6
Other	4	5.4
Total	74	100.0

How many teachers have been involved in exchange visits

Number	Frequency	Percent
0	35	47.3
1	1	1.4
2	6	8.1
3	4	5.4
4	2	2.7
5	4	5.4
8	1	1.4
9	1	1.4
28	1	1.4
Not applicable	19	25.7
Total	74	100.0

Percentage of total teachers involved in Exchange Visits is:

$$89/1778=0.005*100=5\%$$

How many teachers have been trained on interactive learning methods		
Number	Frequency	Percent
0	26	35.1
1	5	6.8
2	21	28.4
3	2	2.7
5	3	4.1
5	2	2.7
29	2	1.4
98	2	1.4
Not applicable	13	17.6
Total	74	100.0

Percentage of total teachers who have been trained on Interactive Education is:

$$202/1778=0.114*100=11.4$$

How many teachers are conducting interactive lessons on HIV/AIDS		
Number	Frequency	Percent
0	21	28.4
1	3	4.1
2	11	14.9
3	2	2.7
5	2	2.7
6	2	2.7
7	2	2.7
8	1	1.4
9	1	1.4
10	1	1.4
14	2	2.7
15	1	1.4
16	1	1.4
22	1	1.4
23	1	1.4
24	1	1.4
27	1	1.4
28	1	1.4
38	1	1.4
48	1	1.4
Not Applicable	10	23
Total	74	100.0

Percentage of total teachers who are conducting interactive lessons on HIV/AIDS is:

$$636/1778=0.204*100=20.4$$

How many teachers are proficient in interactive methods?		
Number	Frequency	Percent
0	19	25.7
1	3	4.1
2	5	6.8
3	3	4.1
5	3	4.1
6	3	4.1
7	2	2.7
8	1	1.4
9	1	1.4
11	1	1.4
23	1	1.4
27	1	1.4
29	1	1.4
30	1	1.4
31	1	1.4
64	1	1.4
Not Applicable	28	28.0
Total	74	100.0

Percentage of total teachers who are conducting interactive lessons on HIV/AIDS is:

$$287/1778=0.161*100=16.1$$

How many meetings in the past 12 months were held by peer educators?		
Number	Frequency	Percent
0	12	16.2
1	5	6.8
2	9	12.2
3	11	14.9
5	6	8.1
6	5	6.8
8	1	1.4
9	2	2.7
10	1	1.4
11	1	1.4
12	1	1.4
15	3	4.1
16	1	1.4
Not Applicable	13	17.6
Total	74	100.0

How many anti-AIDS clubs are there in your institution?		
Number	Frequency	Percent
0	22	29.7
1	26	35.1
2	6	8.1
3	2	2.7
5	1	1.4
6	3	4.1
18	1	1.4
20	1	1.4
Not Applicable	12	16.2
Total	74	100.0

What interactive methods are used by the school?		
Number	Frequency	Percent
None	2	2.7
Discussions	1	1.4
Visiting the sick	1	1.4
Watching videos	10	13.5
Seminars	1	1.4
Media	4	5.4
Lecturing	5	6.8
PACT	6	8.1
Not Applicable	44	59.4
Total	74	100.0

Number of Schools with different ANTI AIDS clubs

CLUBS	FREQUENCY	PERCENTAGES
HIV/AIDS club	20	27.0
PACT	4	5.4
Red Cross	2	2.5
Guidance and Counseling	1	1.4
4B	4	5.4
Scripture Union	18	22.8
Health Club	4	5.4

How many sick leave days were taken by teachers during the year 2002?

NUMBER OF DAYS	FREQUENCY	PERCENT
0	8	10.8
5	1	1.4
6	2	2.7
8	1	1.4
10	1	1.4
11	1	1.4
15	3	4.1
18	1	1.4
20	4	5.4
23	2	2.7
25	2	2.7
30	2	2.7
32	1	1.4
32	2	2.7
33	1	1.4
35	1	1.4
36	1	1.4
37	3	4.1
40	1	1.4
45	1	1.4
47	1	1.4
52	3	4.1

How many sick leave days were taken by teachers during the year 2002?

NUMBER OF DAYS	FREQUENCY	PERCENT
60	1	1.4
61	3	4.1
64	1	1.4
65	1	1.4
72	1	1.4
77	2	2.7
96	1	1.4
105	1	1.4
122	1	1.4
143	1	1.4
162	1	1.4
180	1	1.4
183	1	1.4
417	18	24.4
TOTAL	74	100.0

APPENDIX F STUDENT QUESTIONNAIRE

**BASELINE STUDY ON TEACHER CAPACITY BUILDING
PROJECT FOR HIV/AIDS PREVENTION**

STUDENT QUESTIONNAIRE

Inspectoral Area

School Category

School Number

Date ____/____/____

Self Administered

Personal Interview

Assisted self Administered

PLEASE DO NOT WRITE YOUR NAME ON THIS

STATEMENT OF CONFIDENTIALITY

I have a few questions that I would like to ask you. Some of them ask about personal and sensitive subjects, so I want to remind you that nobody here will see your answers. Several students like you will be asked to complete this questionnaire and hand it to BIDPA research team. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent.

INSTRUCTIONS

1. Please try to answer every question, unless you are asked to skip questions that do not apply to you or your situation.
2. After you have answered all the questions, please put the questionnaire in the envelope and seal it. If any part of the questionnaire doesn't make sense to you, please ask for clarification, but don't show your answers to anyone.
3. Please feel free to write notes about things you feel are important. Use the left margins and blank spaces for this purpose.

THANK YOU FOR YOUR TIME AND COOPERATION

SECTION I –SOCIO-DEMOGRAPHICAL PROFILE

i) Sex Male ☐
 Female ☐

ii) Age at last birth day _____ years

iii) Marital Status Single ☐
 Married ☐
 Cohabiting ☐
 Separated ☐
 Divorced ☐

iv) Sexual Orientation:

Heterosexual (person who prefer sex with opposite sex) ☐
Homosexual (men who prefer sex with other men) ☐
Lesbian (women who prefer sex with other women) ☐
Bisexual (person who prefer sex with both men and women) ☐

v) Level of Education at which you are studying:

Standard ☐
Form ☐
Year of study ☐

vii) Number of years in this school/institution _____

SECTION II- KNOWLEDGE OF HIV/AIDS RISK FACTORS AND MODES OF TRANSMISSION

1. Have you ever heard of an illness called AIDS? Yes ☐ No ☐

2. Is there anything a person can do to avoid getting the virus that causes AIDS?
Yes ☐ No ☐

3. What can a person do to avoid getting the virus that causes AIDS? (Tick appropriate box (s))

- | | |
|---|--------------------------|
| Abstain from sex | <input type="checkbox"/> |
| Use condoms | <input type="checkbox"/> |
| Limit sex to one partner | <input type="checkbox"/> |
| Avoid sex with prostitutes (commercial sex workers) | <input type="checkbox"/> |
| Avoid sex with person with many partners | <input type="checkbox"/> |
| Avoid sex with persons of same sex | <input type="checkbox"/> |
| Avoid sex with person who inject drugs | <input type="checkbox"/> |
| Avoid blood transfusions | <input type="checkbox"/> |
| Avoid injections | <input type="checkbox"/> |
| Avoid kissing | <input type="checkbox"/> |
| Avoid mosquito bites | <input type="checkbox"/> |
| Seek protection from traditional healers | <input type="checkbox"/> |
| Avoid sharing razor blades | <input type="checkbox"/> |
| Other (specify) _____ | |

SECTION III- BEHAVIOUR

4. Have you ever had sex before? Yes ☐ No ☐ (If No go to 8)

5. What was your age at first sex? _____ years Age of partner _____ years

6. Did you use a condom at first sex Yes ☐ No ☐

7. When was the last time you had sexual intercourse?

Days ago (less than 7 day) ☐

Weeks ago (less than a month) ☐

Months ago (less than a year) ☐

7a. Age of partner _____ years

8. The last time you had sexual intercourse, did you use a condom?

Yes ☐ No ☐ (If No go to 11)

9. What was the main reason you used a condom on that occasion?

Prevent STDs/HIV

Prevent pregnancy ☐

Prevent STDs/HIV pregnancy ☐

Does not trust partner ☐

Partner has other sexual partners ☐

Partner insisted ☐

Other (Specify) _____

10. What is your relationship to the person with whom you last had sex?

Husband/boyfriend ☐

Wife/girlfriend ☐

Casual acquaintance ☐

Relative ☐

Other (specify) _____

11. For how long have you had a sexual relationship with this person? (specify number)

Days ago

Weeks ago

Months ago

Years

12. Did you agree to have sex? Yes No (If Yes go to 14)

13. What was the reason for having sex with this person?

Money Forced Other (specify) _____

14. Do you think your partner has other sexual partners?

Yes No

15. Did you have multiple partners during past 12 months? (more than one partner at a time)?

Yes Age of partners _____ No

16. Did you have serial partners during the past 12 months? (sex with a different person at a time)

Yes Age of partners _____ No

17. The last time you had sex with these other persons, did you use a condom?

Yes No

18. Do you ever refuse sex without a condom?

Never Always Sometimes

19. Do you know of a place where one can get condoms? Yes No

20. Where is that? Hospital

Government health centre

Family planning clinic

Mobile clinic

Field worker

Private hospital

Pharmacy

Private doctor

Shop

Church

Friends/Relatives

Other (Specify) _____

21. If you wanted to, could you yourself get a condom? Yes ☐ No ☐ Don't know ☐

22. Have you had a problem getting condoms? Yes ☐ No ☐ (If No go to 24)

23. Main reasons for failing to get condoms:

24. How can you describe the treatment you get from health facilities?

Very good	<input type="checkbox"/>
Good	<input type="checkbox"/>
Average	<input type="checkbox"/>
Poor/Not good at all	<input type="checkbox"/>

SECTION IV- HIV/AIDS SCREENING

25. During the last 12 months, have you had a sexually transmitted disease? Yes ☐ No ☐

26. If you a sexually transmitted infection what would you do?

Seek advice from a health worker in a clinic or hospital ☐

Seek advice or medicine from a traditional healer ☐

Seek advice or buy medicines in a shop or pharmacy? ☐

Ask for advice from friends or relatives? ☐

Other (Specify) _____

27. How can a person find out if he or she has HIV (the virus that causes AIDS)?

Go for a test ☐

Go to health facility ☐

Go to counseling/Testing Facility ☐

Other (Specify) _____

28. Have you ever heard of an HIV/AIDS counseling and testing service? Yes ☐ No ☐

29. What do you think are the reasons to get an HIV test?

Marriage ☐

Family planning ☐

Insurance ☐

Plan for the future ☐

Protect partner ☐

Protect child ☐

If I'm sick ☐

Other (Specify) _____

30. What would be reasons not to get an HIV test?

- | | |
|---|--------------------------|
| Lose job | <input type="checkbox"/> |
| Lose terminal benefits | <input type="checkbox"/> |
| Lose pension | <input type="checkbox"/> |
| Lose partner | <input type="checkbox"/> |
| Fear of knowing | <input type="checkbox"/> |
| Stigma (Afraid of what other people would say or do | <input type="checkbox"/> |
| Other (Specify) _____ | |

31. If you wanted an HIV test, where would you go?

- | | |
|-----------------------|--------------------------|
| Hospital | <input type="checkbox"/> |
| Health clinic | <input type="checkbox"/> |
| Testing centre | <input type="checkbox"/> |
| Other (Specify) _____ | |

32. Would you talk to your partner or parents before having an HIV test?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

33. Would you tell your partner or parents the results of an HIV test?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

34. Which of the following sources provide you with information about sex and HIV/AIDS?

- | | |
|-----------------------|--------------------------|
| Television | <input type="checkbox"/> |
| Sex Education | <input type="checkbox"/> |
| Magazines | <input type="checkbox"/> |
| Friends | <input type="checkbox"/> |
| Relatives | <input type="checkbox"/> |
| Teachers | <input type="checkbox"/> |
| Other (Specify) _____ | |

35. Which of the following statements describe the sex education you receive?

Lessons about condom use ☐

Lessons about healthy life styles ☐

Lessons on HI/AIDS ☐

Lessons on human sexuality ☐

Lessons about risks of unprotected sex ☐

Other (Specify) _____

36. What does unprotected sex mean to you?

Sex without condom ☐

Sex without any contraceptive ☐

Sex with more than one partner ☐

Sex without any clothes on ☐

37. Have you ever been tested for HIV/AIDS? Yes ☐ No ☐ (If No go to 41)

38. Did you receive counseling before getting tested? Yes ☐ No ☐

39. I don't need to know the actual results of your HIV/AIDS test, but did you receive the results? Yes ☐ No ☐

40. Did you receive counseling after getting your results? Yes ☐ No ☐

STIGMA

41. If a relative of yours became sick with the AIDS would you be willing to care for him/her in your home Yes ☐ No ☐ Don't know ☐ (If Yes go to 43)

42. Why would not be willing to care for a sick relative?

43. If a teacher is HIV positive, but is not sick, should he or she be allowed to continue teaching in school? ☐ ☐ Don't know ☐ (If Yes go to 45)

44. Why do you think an HIV positive teacher should not be allowed to continue teaching?

45. Would you play with a student who is HIV positive?

Yes ☐ No ☐ Don't know ☐

46. Why would you not play with an HIV positive student?

SECTION V- SOURCES OF CARE AND SUPPORT FOR PERSONS LIVING WITH HIV/AIDS

47. Think back over the past 12 months. Has anyone in your household, including yourself, been very sick or bedridden for a period of more than three months, or has anyone died after being sick for more than three months? ☐ ☐ (If No go to 50)

48. How old was/were the people who were sick or who died?

Enter ages for all who have been sick or who died after a long illness

	Age of those that were sick	Age of those that died
1		
2		
3		
4		
5		
6		

49. Did your household receive any help or care from outside the household because of the sick person? childcare, food, transportation etc. ☐ ☐ Don't ☐ know

SECTION VI – INTERACTIVE LEARNING

50. Tick the statement that best describes how often your teachers uses each of the following in class:

Never =1 Rarely=2 Sometimes=3 Often = 4 Always=5

Method	1	2	3	4	5
Teacher allows us to work in small groups					
We get a lot of practice writing					
We are allowed to pursue different activities in class					
We do a lot of whole class discussion					
Teacher asks the class questions and some answer					
Teacher gives us a chance to find out things for ourselves					

APPENDIX G TEACHER QUESTIONNAIRE

BASELINE STUDY ON TEACHER CAPACITY BUILDING PROJECT FOR HIV/AIDS PREVENTION

TEACHER/SCHOOL QUESTIONNAIRE

Inspectoral Area

School Category

School Number

Date ____/____/____

Self Administered ☐

(Please tick appropriate)

Personal Interview ☐

Assisted self Administered ☐

PLEASE DO NOT WRITE YOUR NAME ON THIS!

STATEMENT OF CONFIDENTIALITY

The following questions are about HIV/AIDS. We know that you have probably talked about HIV/AIDS with the people who work here. The Botswana Institute for development Policy Analysis (BIDPA) is doing the research on Teacher Capacity Building Project (TCBP) for HIV/AIDS prevention on behalf of Ministry of Education. The TCB project focuses primarily on the teacher with student being the secondary target. This questionnaire seeks to establish baseline data that will provide useful input in development of the Monitoring and Evaluation plan and data collection for HIV/AIDS. Your school has been selected for this exercise.

You are kindly asked to fill in the questionnaire in private. Nobody here will see your answers. Several teachers like you will be asked to complete this questionnaire and hand it to BIDPA research team. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent.

INSTRUCTIONS

4. Please try to answer every question, unless you are asked to skip questions that do not apply to you or your situation.
5. After you have answered all the questions, please put the questionnaire in the envelope and seal it. If any part of the questionnaire doesn't make sense to you, please ask for clarification, but don't show your answers to anyone.
6. Please feel free to write notes about things you feel are important. Use the left margins and blank spaces for this purpose.

THANK YOU FOR YOUR TIME AND COOPERATION

SECTION I –SOCIO-DEMOGRAPHICAL PROFILE

i) Sex Male ☐
 Female ☐

ii) Age at last birth day _____ years

iii) Marital Status Single ☐
 Married ☐
 Cohabiting ☐
 Separated ☐
 Divorced ☐

iv) Sexual Orientation: Heterosexual ☐
 Homosexual ☐
 Lesbian ☐
 Bisexual ☐

v) Level of Education at which you teach:
 Tertiary ☐
 Senior Sec ☐
 Junior Sec ☐
 Primary ☐

vi) Position _____

vii) Number of years in teaching _____

SECTION II – KNOWLEDGE ABOUT HIV/AIDS

1. How is HIV/AIDS transmitted?

- (Please tick appropriate box (s))
- | | |
|--------------------------------|--------------------------|
| A. Unprotected Sex | <input type="checkbox"/> |
| B. Protected Sex | <input type="checkbox"/> |
| C. Kissing | <input type="checkbox"/> |
| D. Shaking Hands/Hugging | <input type="checkbox"/> |
| E. Sharing utensils | <input type="checkbox"/> |
| F. Sharing toilet/bath tubs | <input type="checkbox"/> |
| G. Sharing needles (drugs) | <input type="checkbox"/> |
| H. Sharing needles (tattoos) | <input type="checkbox"/> |
| I. Having several partners | <input type="checkbox"/> |
| J. Donating Blood | <input type="checkbox"/> |
| K. Blood transfusion | <input type="checkbox"/> |
| L. Mosquitoes or other insects | <input type="checkbox"/> |
| M. Other (specify) _____ | |

2. How is HIV/AIDS prevented?

- | | |
|-----------------------------------|--------------------------|
| A. Using condoms | <input type="checkbox"/> |
| B. Sticking to one sexual partner | <input type="checkbox"/> |
| C. Abstaining from Sex | <input type="checkbox"/> |
| D. Antiretroviral medication | <input type="checkbox"/> |
| E. Having sex with a virgin | <input type="checkbox"/> |
| F. Having several partners | <input type="checkbox"/> |
| G. Consulting traditional doctor | <input type="checkbox"/> |
| H. Vaccination/Immunisation | <input type="checkbox"/> |
| I. Other (Specify) _____ | |

Do you agree with the following views about HIV/AIDS transmission?

3. A person who is HIV positive can look and feel well and healthy?

Yes ☐ No ☐

4. A person who has AIDS can look and feel well and healthy?

Yes ☐ No ☐

5. There is no harm if you have unprotected sex with someone who is infected with HIV.

True ☐ False ☐

6. An HIV positive person who is on antiretroviral drug therapy is unlikely to transmit HIV.

True ☐ False ☐

7. There is no need to worry about using condoms when your sex partner is HIV positive

True ☐ False ☐

8. Unprotected sex is risky for transmitting HIV even for people on antiretroviral drug therapy.

True ☐ False ☐

9. Which of the following are some common symptoms of HIV/AIDS?

Fever, sweats, or chills

☐

Pain in mouth, lips or gums

☐

White patches in mouth

☐

Rashes or sores on skin or around anus or (vagina/penis

☐

Nausea or loss of appetite

☐

Trouble with your eyes

☐

Sinus infection, pain, or discharge

☐

Kaposi's Sarcoma (skin cancer)

☐

Herpes (molelo wa badimo)

☐

Loss of weight

☐

SECTION III BEHAVIOUR

10. Have you ever had sex before? Yes ☐ No ☐ (If No go to 17)
11. Have you consistently used condoms in the last 12 months Yes ☐ No ☐
12. Did you use condoms at first sex? Yes ☐ No ☐
13. Have you had multiple partners in the last 12 months?
Yes ☐ No ☐ (If No go to 14)
14. Have you had orgy or group sex in the last 12 months?
Yes ☐ No ☐
15. How often did you or your partner use condoms during sex?
- | | |
|---------------|--------------------------|
| Always | <input type="checkbox"/> |
| Almost Always | <input type="checkbox"/> |
| Sometimes | <input type="checkbox"/> |
| Almost Never | <input type="checkbox"/> |
| Never | <input type="checkbox"/> |
16. During the past 12 months, did you have sex with someone you knew was HIV positive?
- | | |
|------------|--------------------------|
| Don't Know | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |
17. How often did you or your partner use condoms?
- | | |
|---------------|--------------------------|
| Always | <input type="checkbox"/> |
| Almost Always | <input type="checkbox"/> |
| Sometimes | <input type="checkbox"/> |
| Almost Never | <input type="checkbox"/> |
| Never | <input type="checkbox"/> |
18. How many partners did you have in the last 12 months? _____

19. Number of sexual partners who are at least 10 years younger or more _____

20. How old is your current partner? _____ years

21. Have you or your partner expected a child in the past 3 years?

Yes ☐ No ☐

22. Have you requested and undergone HIV testing in the last 12 months?

Yes ☐ No ☐

23. How old were you at first sex? _____ years

24. Have you ever successfully refused to have sex without a condom?

Yes ☐ No ☐

25. How many sex partner(s) do you have? _____

26. During the past 12 months, did you have sex with a person who ever injected or shot street drugs, steroids, or vitamins?

Don't Know ☐

No ☐

Yes ☐

27. During the past 12 months, did a doctor or nurse tell you that you had a sexually transmitted disease (STD) other than HIV? Yes ☐ No ☐

28. The last time you had sex; did you or your partner use a condom?

Yes ☐ No ☐

29. Did you use a needle (syringe) to inject or shoot street drugs, steroids, or vitamins in the last 12 months? Yes ☐ No ☐ (If No go to 31)

30. What kind of needles did you use? (Check All That You Used)

New Needles ☐

Needles cleaned with bleach ☐

Shared Needles (someone used the needle before you) ☐

Shared Needles (someone used the needle after you) ☐

Don't Know ☐

31. How often were you absent from work due to illness in the past 12 months? _____ days

32. How can a person find out if he or she has HIV (the virus that causes AIDS)?

Go for a test ☐

Go to health facility ☐

Go to counselling/Testing Facility ☐

Other (Specify) _____

33. Have you ever heard of an HIV/AIDS counseling and testing service? Yes ☐ No ☐

34. What do you think are the reasons to get an HIV/AIDS test?

Marriage ☐

Family planning ☐

Insurance ☐

Plan for the future ☐

Protect partner ☐

Protect child ☐

If I'm sick ☐

Other (Specify) _____

35. What would be reasons not to get an HIV/AIDS test?

Lose job ☐

Lose terminal benefits ☐

Lose pension ☐

Lose partner ☐

Fear of knowing ☐

Stigma ☐

Other (Specify) _____

36. If you wanted an HIV/AIDS test, where would you go?

Hospital ☐

Health clinic ☐

Testing centre ☐

Other (Specify) _____

37. Would you talk to your partner or parents before having an HIV/AIDS test?

Yes ☐ No ☐

38. Would you tell anyone the results of an HIV/AIDS test?

Yes ☐ No ☐

39. If yes, which of the following are you most likely to share the results with?

Parents ☐

Partner ☐

Friend ☐

Priest ☐

Teacher ☐

Other (Specify) _____

Please complete this question if you are HIV positive and taking antiretroviral medications.

40. It is very hard for people on HIV antiretroviral drug therapy to take so many pills all the time, so almost everyone misses doses some of the time. During the past 4 weeks, how often have you taken your antiretroviral medications as prescribed?

Never missed a pill (100% of doses taken)

☐

Almost all of the time (>95%, more than 19 of 20 doses taken)

☐

Most of the time (80 - 95%)

☐

Usually (60 - 80%)

☐

About half of the time (40 - 60%, approximately half of doses taken)

☐

Some of the time (20 - 40%)

☐

Very little of the time (<20%, less than 1 of 5 doses taken)

☐☐

41. Does your teaching schedule allow you to take antiretroviral medications as prescribed? Yes ☐ No ☐

42. If No, how do you think the situation could be improved?

SECTION III – INTERACTIVE LEARNING

43. In your opinion what factors hinder students' involvement in interactive learning?

- | | |
|--|----------------------|
| Tiredness | <input type="text"/> |
| Fear of being wrong | <input type="text"/> |
| Insufficient interest in the class | <input type="text"/> |
| Insufficient knowledge about the subject | <input type="text"/> |
| Shyness | <input type="text"/> |
| Insufficient time to formulate ideas | <input type="text"/> |
| Fear of ridicule when giving wrong answers | <input type="text"/> |
| Other (specify) _____ | |

44. What factors support students' involvement in interactive learning? (Please number the following in order of priority where 1= most important and 9 =least important)

- | | |
|--|----------------------|
| Create an informal atmosphere in the classroom. | <input type="text"/> |
| Give a lot of encouraging responses when students speak and participate. | <input type="text"/> |
| Ask questions on topics which students have some knowledge / interested in. | <input type="text"/> |
| Make explicit that students are encouraged to speak in class. | <input type="text"/> |
| Allow students to form groups with friends. | <input type="text"/> |
| Give questions for students to discuss in groups in order to formulate a group answer. | <input type="text"/> |
| Avoid questions that are too easy or difficult. | <input type="text"/> |
| Give students a topic to discuss in advance. | <input type="text"/> |
| Ensure good teacher contentment | <input type="text"/> |
| Ensure students are well disciplined | <input type="text"/> |
| Other (Specify) _____ | |

45. What teaching/learning equipment do you use often in your class?

Teaching/Learning aids		Number
1		
2		
3		
4		
5		
6		
7		

46. In your opinion what factors hinder teachers' implementation of interactive learning?

47. In your opinion what factors supports teachers' implementation of interactive learning? _____

48. Which form of interactive teaching do you normally use and how often? (Please tick the number that best describes how often you use each of the following planning and teaching techniques)

Never = 1, Rarely = 2, Occasionally = 3, Frequently = 4, Always = 5

	1	2	3	4	5
Whole class lessons					
Programmed materials – set assignments					
Role playing or simulations					
Brainstorming or circles of knowledge					
Students design their own learning					
Small group assignments					
Creative activities with students options					
Objectives, varied for individuals					
Class discussion (Question answer)					
Teacher demonstration					
Lecture (whole class)					
Media (films, tapes, etc)					
Individual diagnosis and prescription for each student					
Small groups work (3-8)					

49. Which form of teaching environment do you prefer and how often are students exposed to it? (Please tick the number that best describes how often you use each of the following planning and teaching techniques)

Teaching environment

	1	2	3	4	5
Several small groups					
Pairs					
Independent study assignments					
One-to-one interactions with the teacher					
Two or more of the above groupings at a time					
One large group (entire class)					
Varied instructional areas are provided in the classroom					
for different, simultaneous activities					
Instructional areas are designed for different groups that					
need to talk and interact					
Demanding – with high expectations based on individual					
Ability					

50. Which teaching technique do you use to teach different subjects? (Please state subject and enter method number)

Traditional = 1, Somewhat traditional=2, Transitional=3, Somewhat individualized=4, Highly individualized =5

Subject	Method
1	
2	
3	
4	
5	
6	

APPENDIX H HEADMASTER QUESTIONNAIRE

BASELINE STUDY ON TEACHER CAPACITY BUILDING PROJECT FOR HIV/AIDS PREVENTION

HEADMASTER QUESTIONNAIRE

Inspectoral Area

School Category

School Number

Date ____/____/____

Self Administered

Personal Interview

Assisted self Administered

PLEASE DO NOT PUT YOUR NAME ON THIS!

STATEMENT OF CONFIDENTIALITY

The following questions are about HIV/AIDS. We know that you have probably talked about HIV/AIDS with the people who work here. The Botswana Institute for development Policy Analysis (BIDPA) is doing the research on the Teacher Capacity Building Project (TCBP) for HIV/AIDS prevention on behalf of Ministry of Education. The TCB project focuses primarily on the teacher with student being the secondary target. This questionnaire seeks to establish baseline data that will provide useful input in development of the Monitoring and Evaluation plan and data collection for HIV/AIDS. Your school has been selected for this exercise.

You are kindly asked to fill in the questionnaire in private and hand it to BIDPA research team. Nobody here will see your answers. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent.

INSTRUCTIONS

7. Please try to answer every question, unless you are asked to skip questions that do not apply to you or your situation.
8. After you have answered all the questions, please put the questionnaire in the envelope and seal it. If any part of the questionnaire doesn't make sense to you, please ask for clarification, but don't show your answers to anyone.
9. Please feel free to write notes about things you feel are important. Use the left margins and blank spaces for this purpose.

THANK YOU FOR YOUR TIME AND COOPERATION

SECTION I –SOCIO-DEMOGRAPHICAL PROFILE

i). Gender Male ☐
 Female ☐
 Transgender ☐

ii). Age _____ years

iii). Tribe _____

iv). Marital Status:

Single	<input type="checkbox"/>
Married	<input type="checkbox"/>
Cohabiting	<input type="checkbox"/>
Widowed	<input type="checkbox"/>
Separated	<input type="checkbox"/>
Divorced	<input type="checkbox"/>

v). Level of Education:

Tertiary	<input type="checkbox"/>
Senior Sec	<input type="checkbox"/>
Junior Sec	<input type="checkbox"/>
Primary	<input type="checkbox"/>

SECTION II – SCHOOL STATISTICS

1. How many of the following teachers do you have in your school?

A. Temporary teachers: _____

B. Permanent teachers: _____

2. Please provide the following statistics:

A. Total number of boys: _____

B. Total number of girls: _____

C. Grand Total: _____

3. How many classrooms does your school have? _____

4. How many drop-outs did you have due to:

A. Pregnancy: _____

B. Illness: _____

C. Social problems: _____

D. Distance from School: _____

E. Others (Specify) _____

10. How many deaths did you experience from the following groups?

A. Boys _____

B. Girls _____

C. Teachers: i. Males _____

ii. Females _____

11. How many sick leave days were taken by teachers during the year 2002? _____

SECTION III – INTERACTIVE LEARNING

6. Does the school/institution have a teacher capacity building team? Yes ☐ No ☐

7. How many teachers have been involved in exchange visits? _____

8. How many teachers have been trained on interactive education? _____

9. How many teachers are conducting interactive lessons on HIV/AIDS? _____

11. What interactive methods are used in your school?

12. How many teachers are proficient in interactive methods? _____

13. How many anti-AIDS clubs are there in your institution? _____

14. How many meetings in the past 12 months were held by peer educators? _____

APPENDIX I FOCUS GROUP SCHEDULE

BASELINE STUDY ON TEACHER CAPACITY BUILDING PROJECT FOR HIV/AIDS PREVENTION

FOCUS GROUP DISCUSSION CHECKLIST

KNOWLEDGE ABOUT HIV/AIDS

1. How many of you have ever heard of an illness called HIV/AIDS? _____

2. How many of you have never heard about HIV/AIDS? _____

3. Where did you get information about AIDS/HIV?

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

4. How can one contract HIV/AIDS?

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

5. Is there anything a person can do to avoid getting AIDS or become HIV positive?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

6. How can a person find out if he or she has HIV (the virus that causes AIDS)?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

7. What do you think are the reasons to get an HIV/AIDS test?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

8. What would be reasons not to get an HIV/AIDS test?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

9. If you wanted an HIV/AIDS test, where would you go?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

10. Who should go for an HIV/AIDS test?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

11. What are the common symptoms of HIV/AIDS?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

12. What does unprotected sex mean?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

13. Who should be responsible for taking precautions during sex?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

CONDOM ACCESS

14. You mentioned use condoms as one way of preventing contracting HIV/AIDSs, where does one get condoms?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

15. Do you ever have problems getting condoms? If so what the reason?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

16. How Are you happy with sex and HIV/AIDS information you receive in schools?

16a. If not, why so?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9

17. What suggestions do you have to improve the current sex education needed to effect changes in behavior in order to reduce the spread of HIV/AIDS?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9
- 10

STIGMA

18. Would you interact with a person who is HIV positive or who has AIDS?

How many of you would:

A. Play with a person who is HIV positive or is suffering from AIDS? _____

B. Kiss a person who is HIV positive or is suffering from AIDS? _____

C. Hug a person who is HIV positive or is suffering from AIDS? _____

D. Shake hands a person who is HIV positive or is suffering from AIDS? _____

E. Agree to be taught by a teacher who is HIV positive or is suffering from AIDS ? _____

