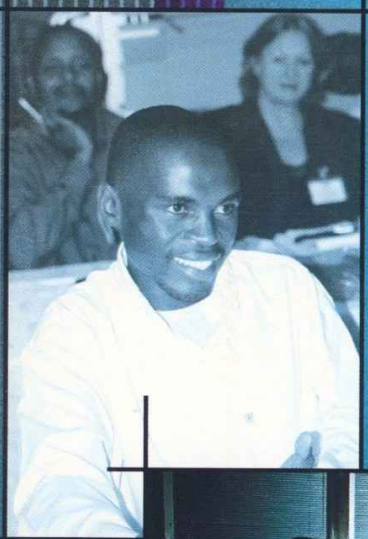
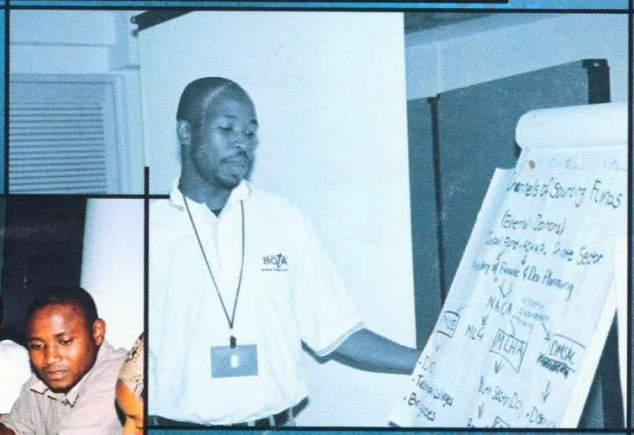
Knowledge, Attitudes and Behaviour

Towards HIV and AIDS of Vocational Trainees in Botswana





BOTA

BOTSWANA TRAINING AUTHORITY

Knowledge, Attitudes and Behaviour Towards HIV and AIDS of Vocational Trainees in Botswana

Authors:
CHARITY K. KERAPELETSWE
LISENDA LISENDA
BOTSWANA INSTITUTE OF DEVELOPMENT POLICY ANALYSIS

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BOTA Research in Vocational Training Series (BRVTS)

The BRVTS is the primary vehicle for disseminating major research work of BOTA. The series aims to capture the research information on Vocational Training in Botswana being generated at BOTA or on behalf of BOTA and publish it for information of staff, stakeholders and the research community at large. This publication is the first one in the series and is a result of a study done on behalf of BOTA by Dr. Charity Kerapeletswe and Mr. Lisenda Lisenda of the Botswana Institute of Development Policy Analysis. The research came about because of the need to set a baseline for the subsequent measurement of the impact of BOTA mainstreaming programmes for HIV and AIDS within the Vocational Training Sector. The participants in the research were on average within the age group that has one of the highest risks of HIV infection in the country.

The work therefore adds an important element to the body of information on the Knowledge, Attitude and Behaviour towards HIV and AIDS of this particular section of young people within the Vocational Training System of Botswana.

Series Editor

Ezekiel Thekiso, Director of Planning and Research (BOTA)

This report has been produced by Botswana Institute for Development Policy Analysis (BIDPA) on behalf of the Botswana Training Authority (BOTA). Although BIDPA has taken reasonable care to ensure that the information, data and other material made available in this report is error-free and up-to-date, it accepts no responsibility for any defects caused by the transmission or processing of the information, data and other material. The responsibility for opinions expressed in the report rests solely with the author and the publication does not constitute an endorsement by BOTA of opinions expressed in them.

The report contains findings of a consultancy on the Knowledge, Attitudes and Behaviour (KAB) of Students in the Vocational Training Sector. The main objectives of KAB study are to assess the level of knowledge about different aspects of HIV and AIDS; to examine the attitude of the study group towards HIV and AIDS; to assess the sexual behaviour and practices of these learners; to assess the scope of risk behaviour related to the possibilities of getting infected with HIV; to assess the attitudes and stigma related to HIV problems; to identify information sources, where data on HIV and AIDS topics are obtained and could be obtained; and to evaluate the effectiveness of existing programmes about HIV and AIDS. The information on these issues will assist in developing a strategy to curb the spread of HIV and make the relevant information more accessible for the learners. A multi-disciplinary was drawn from BIDPA lead by Dr C.K Kerapeletswe. The team comprised Mr Lisenda Lisenda, Ms Kealeboga Gaboeletswe, Ms Barbara Dibe, Mr Edward Semauswane and Ms Tshegofatso Hambira.

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BIFM House, Main Mall, Gaborone
Private Bag BO 340, Gaborone, Botswana
Tel.: (+267) 3159481/2 • Fax: (+267) 3952301
Email: info@bota.org.bw
www.bota.org.bw

Research Authors: Charity K. Kerapeletswe, BIDPA, Lisenda Lisenda, BIDPA
Text Editors: Peter Fleming, Chris Batsalelwang

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We would also like to acknowledge the important contribution of the reference group, who was an advisor throughout the research process and whose technical and editorial skills greatly assisted in the final preparation of this report.

Charity Kerapeletswe, Lisenda Lisenda

Contents

Acronyms

ABC	Abstain, Be faithful and Condomise
ACHAP	African Comprehensive HIV and AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
BIDPA	Botswana Institute for Development Policy Analysis
BOTA	Botswana Training Authority
BTV	Botswana Television
CEDPA	Centre for Development and Population Studies
CSIS	Centre for Strategic and International Studies
CSO	Central Statistics Office
GDP	Gross Domestic Product
GOB	Government of Botswana
HIV	Human Immunodeficiency Virus
KAB	Knowledge Attitude and Behaviour
MoE	Ministry of Education
NACA	National Aids Coordinating Centre
NGO	Non Governmental Organisation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TC	Technical Colleges
UNAIDS	United Nations Aids Programme
UNCEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YOHO	Youth Health Organisation

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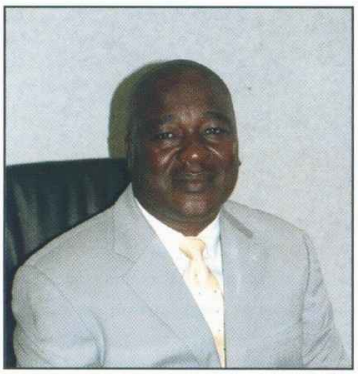


Foreword

by **Abel Modungwa,** *Chief Executive Officer, Botswana Training Authority (BOTA)*

Botswana has for years been listed as the country in the world with the highest HIV infection rate, a record only recently taken over by Swaziland. The international widely quoted HIV prevalence rates in Botswana, based on pregnant women aged 15-49 years was 38.5 percent in 2000 and 36.5 percent in 2001.

However, the 2004 Botswana AIDS Impact Survey conducted by Botswana's Central Statistics Office and the National Aids Coordinating Agency (NACA), working with development partners, found that the national HIV prevalence rate was 17.3 percent. Given Botswana's relatively low population of 1.7 million, the survey's results are believed to be highly representative. However, the national rate of 17.3 percent should not be viewed to provide any form of comfort because HIV prevalence rates are above 30 percent among young adults. The survey also confirmed that among those below 40, the prevalence rate is significantly higher among females than males.

The Botswana Training Authority (BOTA) recognizes its responsibility, based on the national HIV and AIDS Strategy of Botswana, to mainstream HIV and AIDS within its organization and in the vocational training sector. An HIV and AIDS Division was established in 2002 to coordinate and monitor the HIV and AIDS activities in the vocational training institutions. Efforts have been done to implement HIV and AIDS policies in the institutions covering prevention strategies and support to infected and affected trainers and learners. The HIV and AIDS Division of BOTA has conducted training on peer education, HIV and AIDS and counselling and workshops for extra curricula activities such as drama coaching. Information, education and communication materials were promoted to the vocational training institutions on a regular basis.

Although the evaluation of HIV and AIDS training and workshops showed the high acceptance by the participants, it was not researched if training and workshops contribute towards behavioural change of the learners to reduce the spread of the epidemic. Behavioural change has been recognised as being vital to safeguard the workforce in the country. In addition, there was limited information on the level of knowledge on HIV and AIDS amongst the learners in the vocational training sector. In 2001, the Ministry of Health carried out a baseline study on knowledge attitude, behaviour and practice of adolescents and youth on sexual and reproductive health. This important study and existing researches on HIV and AIDS at the workplace, conducted in several companies, could not address the special situation of learners in the vocational training sector..

BOTA decided to carry out a baseline study on HIV and AIDS in the vocational training sector. The baseline study on knowledge attitude, behaviour towards HIV and AIDS was designed to submit data on the level of knowledge amongst learners in the vocational training institutions as well as their attitude and behaviour regarding HIV and AIDS. The goal of the study was to come up with recommendations to guide implementers on HIV and AIDS interventions.

The research was conducted by Botswana Institute for Development Policy Analysis (BIDPA) on behalf of BOTA. Quantitative and qualitative questionnaire data were collected amongst learners from January to March 2005 in sampled vocational training institutions in the country.

We hope the findings of the study will benefit those who consider further investigating HIV and AIDS prevention strategies and interventions. At least, the study is a significant work responding to the HIV and AIDS epidemic in the Vocational Training Sector in Botswana. This study will be of interest not only to people working in the field of HIV and AIDS in Botswana, but also abroad to support the common fight against HIV and AIDS.

Executive Summary

The HIV and AIDS pandemic is steadily increasing in severity throughout the developing world. Most of Africa is experiencing surging prevalence and incidence rates of HIV infection. One particular country of interest is Botswana.

Even though, they have knowledge about HIV and about modalities of transmission, many learners in training institutions in Botswana do not perceive themselves as being at risk of infection. In order to decrease transmission rates among learners, quality HIV and AIDS education must be implemented in a culturally relevant manner.

This report is based on a national survey of vocational learners. The survey was conducted January to March 2005 among a nationally representative sample of 1297 learners. In addition about 690 learners participated in focus group discussions. The survey was designed to shed light on the level of knowledge, attitude, sexual behaviour and practices towards HIV and AIDS among learners in vocational training institutions in Botswana, and to come up with recommendations to guide implementers on HIV and AIDS interventions in vocational training institutions. The analysis of the field survey data shows high levels of HIV and AIDS awareness among learners in the vocational training sector. However, awareness and knowledge of some learners are not linked to behavioural change. The responses to the survey questions appeared to reflect the "socially acceptable" behaviour, but actions were often completely different.

There are strong indications that the learners in this study have good access to accurate HIV and AIDS information and that they are regularly being exposed to HIV and AIDS media from a range of different sources. It is further encouraging noting that training institutions are an important sources of information to about 50% of learners. Learners' major sources of HIV and AIDS information are TV, magazines and parents; they also indicate that the best strategy to increase learners' knowledge is through health education. It is further encouraging noting that Parents/guardians play an active role as a source of information for learners on HIV and AIDS issues.

Over 95% of learners are very knowledgeable about ways to avoid getting infected with HIV. Learners correctly picked things a person can do to avoid getting infected with the HIV as follows: at least 90 percent of learners correctly selected abstinence; condom use by about 80% of learners; whilst sticking to one partner was selected by 50%; and followed by avoiding sex with prostitutes and many partners. More positively, the majority of learners, about 89%, indicated that the last time they had sex before the survey, they used condoms. The majority of learners, 86%, across all vocational training institutions indicated that they could get condoms easily if they wanted them. However a significant number indicated that they couldn't, because their close relatives are working in places they could get condoms. For most sexually active learners, hospitals, family planning clinics and government health centres are the main three places to get condoms. However, about 33% of learners rated the treatment they get from health facilities as average, 30% rated it very good, 25 % good, and 13% rated the treatment poor.

But there are many challenges: About 16% of Brigades, 19% of private institutions and 17% of TC learners are of the view that HIV is transmitted by simple casual contact, such as, kissing, sharing water glasses and hugging. Such misperceptions about HIV and AIDS were also noted, with student's response to the statement, "AIDS is the most advanced stage of HIV infection", where 18% of Brigades, 13% of VTC and about 6% of private institutions learners disagreed. Data shows that the majority of those who held such misperceptions about HIV and AIDS are mostly new entrants (or first year learners), particularly male learners, in all three training institutions. In addition, a significant percentage of sexually active learners engage in risky unprotected sex as 20% indicated that they never refuse sex without a condom, and the other 20% sometimes refuse sex without a condom. Although they majority practice safe sex, there is need for awareness programmes on the danger of unprotected sex, particularly targeted towards male learners who are in the majority of those who never refuse sex without a condom. This is further compounded by the fact that almost half of learners, 49%, have never tested for HIV and AIDS, citing fear of being stigmatized and discrimination, especially among those in Brigades and private vocational institutions. Vocational institutions should therefore encourage learners to voluntarily go for HIV testing, as the absence of such encouragement may worsen the HIV infection among learners. This highlights that a lot of learners are exposed to the dangers of being infected with HIV or falling pregnant as was noted in focused group discussions. The need for more aggressive information on safe sex, and

from differentiated sources, particularly, from television programmes, institutional videos, and pamphlets on HIV and AIDS beckons in all vocational institutions.

The challenges may be complicated by the reported incidence of commercial sexual activity among a few sexually active learners, who reported that there is a lot of commercial sex done by female learners, as a way of dealing with their financial needs. The survey also learnt that in some cases learners face difficulties asking their older partners to use condoms, as it is usually the older partner who makes the decision. Nonetheless, data indicate that some key opportunities exist to influence positive behaviours. It is encouraging to see that the majority of learners, over 45%, across institutions, had only one partner during the past year. Over 20% of learners across three institutions had two partners in the last year. All this suggests to some degree that the public education awareness programmes on issues of HIV and AIDS, particularly the one encouraging people to stick to one partner is bearing fruit. However, there is need to maintain the momentum, and keep such awareness programmes going, so as to convert the few learners who still have a high exchange rate of partners. Although the majority of learners believe that abstinence is the only way to avoid getting infected with the virus that causes AIDS, there is still hope as 14% never had sex, and programmes should target such learners to further delay or encourage them to engage in safe sex in the event they decide to start.

An assessment of the impact of peer educators, counsellors, and drama lessons on the knowledge, attitudes and behaviour of learners towards HIV and AIDS reveals that albeit irregularity and underdevelopment the programmes are successfully reaching and changing the behaviour of a significant proportion of learners. Learners who attended any of these sessions generally have a very positive assessment of them and their impact on them. Moreover, many learners, including those who are sexually experienced, report that they have taken positive action in response to these lessons that could decrease their risk of HIV infection. In addition, learners who attended these lessons indicate that they value communication and that they have given them the opportunity to talk to their partners and parents about sensitive issues such as sex and relationships.

In sum, this survey shows that improvements of peer education, drama competition, and counselling services in vocational institutions across Botswana will positively impact on the knowledge, attitudes and behaviour of learners towards HIV and AIDS, as it is paying early dividends. All signs are that the programmes offer great promise to positively impact the lives of learners and reduce their risk of HIV infection, but much work remains to be done to regularize, and engage competent counsellors. These programmes should be designed to target HIV and AIDS knowledge deficient groups such as new entrants in vocational institutions, and particularly male learners.

The study shows a generally high perception of vulnerability to HIV infection (personalising of perception of risk), although with varying levels of preventive response to such awareness. Access to media expands one's awareness level and further information that is required is perceived as being available within the social network rather than through experts. This is an indication that learners feel empowered in the sense of having the knowledge available to deal with HIV and AIDS. Learners in rural areas have lowest access to and score lower on risk and prevention issues.

Summary of Conclusions

Lessons that emerge clearly from the study are that learners have the correct knowledge about HIV prevention and how it is transmitted. The report shows that there is a significant percentage that is not practicing the two most effective ways of preventing infection and unwanted pregnancy which are abstinence and consistent condom use. This is further compounded by the prevalence of commercial sex among learners, particularly female learners. The report also found that the majority of learners practice safe sex, but there is need for awareness programmes on the danger of unprotected sex, particularly targeted towards male learners who are in the majority of those who never refuse sex without a condom. Even more troubling is the fact that half of learners have not tested for HIV, which by itself, exposes them to the risk of infection. More encouraging is the finding that parents have started to participate more actively as a source of information on HIV and AIDS to learners. It is further encouraging noting that in a majority of cases the decision to have sex is undertaken wilfully by both partners. However in a significant percentage of cases male learners still dominates female learners in decisions relating to sex.

Participants at BOTA HIV & AIDS Stakeholders Workshop - March 2006

Recommendations

Intervention programmes to empower females cannot work unless there is also work to change the behaviour of the other half viz. males. There is need to motivate both males and females to talk openly about sex, and HIV and AIDS, and encourage males to take care of themselves, their partners and their families. Strategies that engage males as partners in fighting AIDS are surest way to change the course of the epidemic.

Teachers need to be trained, to acquire skills to impart or teach HIV and AIDS issues more comfortably, and parents also need to be encouraged to discuss more openly HIV and AIDS and sexual health needs of learners. This study indicates the need for further operations/intervention research to discover what strategies would work best to encourage behavioural change, improve the sexual and HIV and AIDS knowledge, and health of learners in the vocational training sector. These include activities targeting teachers as well as working with parents and learners.

nterventionprogrammes to empower females cannot work unless there is also work to change the behaviour of the other half viz. males. There is need to motivate both males and females to talk openly about sex, and HIV and AIDS, and encouraging males to take care of themselves, their partners and their families. Strategies aimed at encouraging behavioural change of men in the fight against AIDS should be emphasised.

HIV and AIDS focal persons should be trained to acquire skills on how to impart issues of HIV and AIDS to learners effectively. They should also be able to encourage parents to discuss issues of HIV and AIDS and sexual health needs of learners. Furthermore, there should be strategies for instilling behavioural change in VT learners and enhancing sexual, health and HIV and AIDS knowledge.

Sex educators and HIV and AIDS coordinators should be equipped with skills that would enable the learners to develop skills and abilities to be sexually responsible.

BOTA should encourage the training institutions to set up user-friendly, safe and easily accessible condom distribution points within the institutions by installing condom dispensers at strategic places such as toilets and hostels.

There is need for education programme frameworks that address positive-learner development as a longer term goal. Learners must continue to be involved and encouraged to openly present their views in educational programme design in order to assure programme relevance, ownership and participation.

Training institutions should create linkages between skills development and income generating programmes such as micro- enterprises, livelihood projects to promote gender equity at the individual and societal levels to empower female learners and subsequently reduce their desire to engage in commercial sex and other risky behaviours.

Mass media and informal communications, peer education and drama competitions can help break taboos on sensitive topics and promote the discuss-ability of sex and HIV and AIDS, assist in the process of changing social norms, reach large numbers at a modest cost and disseminate practical information. Researchers need to explore the risk factors for males and females in the use of condoms to help determine the type of interventions suitable for each category.

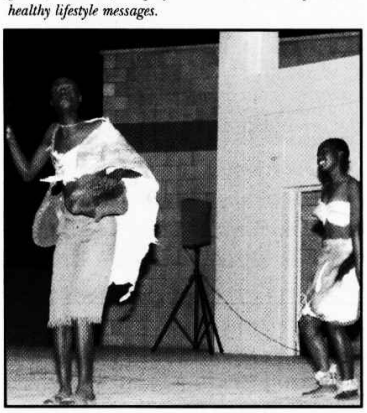
Education campaigns on issues of HIV and AIDS should take account of age differences and situations and address them accordingly. Formal and informal sex/HIV education programs should identify learners' popular venues for reaching learners with needed information.

There is need to adopt community-based strategies that involve community leaders in campaigns to change the traditional practices, beliefs and stereotypes that increase vulnerability of females and males to HIV. This will encourage both males and females to take joint responsibility for protecting one another from infection.

Modules/sessions on HIV and AIDS in vocational institutions should include several strategies like the use of condoms, sticking to one partner, promiscuity, avoiding many partners, and abstinence. These should also encourage positive decision making, respect and understanding of partners decisions relating to lovemaking.

Information on voluntary counselling and testing should be made available in all vocational institutions to encourage learners to voluntarily test for HIV and AIDS.

Employ a variety of methods such as films, drama, poems, games, talkshows, role plays and edutainment to promote healthy lifestyle messages.



1. Introduction

The research on Knowledge, Attitudes and Behaviour towards HIV and AIDS in the Vocational Training Sector was carried out from January to March 2005. The research was commissioned by the Botswana Training Authority (BOTA) and conducted by Botswana Institute for Development Policy Analysis (BIDPA) on behalf of BOTA.

The information on these issues will assist in developing a strategy to curb the spread of HIV and make the relevant information more accessible to learners in training institutions. The Vocational Training Sector accorded significant priority to skills training as a means of achieving Botswana development objectives, and to positively aid the government efforts to attract investors to Botswana and diversify the economy. A pool of highly skilled workforce would aid such efforts. The sector provides primary, secondary school leavers, and adult learners with training in a particular career. According to the Education Statistics, in 2001, the sector was made up of 33 Brigades; 10 Technical Colleges; 7 health institutes; a number of private schools (offering computer skills training, and secretarial courses), as well as, work-based training institutions. The areas of concentration most frequently offered by vocational education programmes focus on certificate in secretarial, business, and computer studies; bricklaying, carpentry and other construction related courses; mechanics and electrical courses and other auto related courses; horticulture, livestock farming, borehole mechanic; refrigeration and air conditioning: fishing and boat making; information and communication technology; marketing; textile and tailoring trades; knitting and crocheting; fabric dying and printing, etc.

Approximately 11,507 people aged 16-26 years, were enrolled by the vocational education system in 2001. However, recent surveys and studies observe that the 16-26 years age group, is the most sexually active, dominate the number of unemployed and is the most affected by HIV and AIDS. The HIV prevalence among pregnant women aged 20-24 rose from 20.5% in 1992, peaked at 42.8% in 1998, before declining to 37.4% in 2002 (Botswana National Strategic Framework for HIV and AIDS 2003-2009). This suggests that in the absence of vocational training sector specific response to the HIV and AIDS epidemic, in the form of new interventions and awareness campaigns, the number of quality graduates from the vocational training system available to work will decline over the years. Thus negating all Government's efforts to promote foreign direct investment, diversify the economy, and create employment for Batswana.

The following research report consists of 6 chapters. The first chapter provides an introduction to the study and overview of objectives. The second chapter presents a background to the study with a brief literature review on issues of HIV and AIDS prevalence, factors contributing to the spread of HIV, etc. The third chapter discusses the methodology used in carrying out the research. The latter is followed by the extensive explanations of research results. First, the general socio-demographic background and lifestyle of the studied youth are observed. The overview of the knowledge of the young people in the questions related to HIV and AIDS and of where they receive the relevant information follows. The fifth chapter deals with condom acquisition, access to services and attitudes towards people living with HIV and AIDS. The report ends with the summary of the main observations resulting from the research and recommendations.

The aim for carrying out the current research was to get a better overview of the Vocational Training Sector learner's knowledge, attitudes and behaviour towards HIV and AIDS, with specific objectives:

- To **assess the level** of knowledge about different aspects of HIV and AIDS
- To **examine the attitude** of the study group towards HIV and AIDS
- To **assess the sexual** behaviour and practices of these learners
- To **assess scope of risk** behaviour related to the possibilities of getting infected with HIV
- To **assess the attitudes** and stigma related to HIV problems
- To **identify information** sources, where from data on HIV and AIDS topics are obtained and could be obtained
- To **evaluate the effectiveness** of existing programmes about HIV and AIDS

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2. Background

The joint United Nations Program on HIV and AIDS (UNAIDS) estimates that currently, there are 39.4 million people living with HIV worldwide, with 4.9 million new cases of HIV infection in the year and 3.1 million deaths due to AIDS (Banerjee, and Mattle (2004)). Of the approximately 40 million people afflicted with HIV and AIDS worldwide, the top three locations are in nations of sub-Saharan Africa, with 25.4 million cases, followed by 9.6 million combined cases in nations of Asia and Eastern Europe, and 1 million cases in North America (UNAIDS, 2004).

A joint report on the AIDS pandemic by UNAIDS and the World Health Organization (WHO) stated that AIDS is affecting women and girls in increasing numbers such that globally, almost 50% of all people living with HIV are female and 76% of young people (aged 15-24 years) living with HIV in sub-Saharan Africa are female. The report also pointed to steep increases in HIV infections in East Asia, Eastern Europe and Central Asia between 2002 -2004 (UNAIDS/WHO, 2004).

The WHO states that youths are at the epicentres of preventing the progression of the HIV and AIDS pandemic. The WHO estimates that youths ages 15 to 24 comprise 50% of all new HIV infections and consequently must be targeted for education in decreasing transmission and reducing the stigmatization of an HIV diagnosis (WHO, 2004). In order for youths to help slow this pandemic, they need to first be educated and have knowledge about HIV and AIDS. The research literature on the subject points to a situation where most youth in the world are uninformed or have serious misconceptions regarding pathways of HIV transmission, and also harbour negative attitudes towards the sero-positive population. A United Nations report (2002) stated that most youth do not know the modes of HIV transmission and they also do not know any methods in which they can protect themselves from contracting the virus (Joint Press Release WHO, UNICEF, UNAIDS, 2002). The same study revealed that half of all youth in the countries surveyed, had mistaken beliefs about the transmission of the virus. The same report concluded by revealing two major goals: 1) reduce the number of youth infected with HIV and 2) provide information, education and services to youths across the globe. It is evident that in order to reduce the number of youth who are infected with HIV, misconceptions first need to be evaluated and the proper information taught to this high risk population. In 1993, the World Health Organization commissioned a far-reaching review of published studies examining the reported effects of sex education on young people's sexual behaviour. Grunsiet and Aggleton (1998) concluded from their review of forty-seven studies that the programmes that are most effective in reducing adolescents' high risk sexual behaviour are those that focus on delaying sexual intercourse as well as provide skills and information related to contraception and condom use for pregnancy and STD prevention.

Traditional ways of educating the young about sex have diminished or disappeared altogether. For example, in Botswana many Christian missionaries discouraged initiation rites that defined the passage from youth to adulthood. As a result, opportunities for teaching young people about sex, traditionally a part of those rites, were lost. The social bonds and traditions that used to shape young people's behaviour and help them make the transition to adulthood have weakened in the face of urbanization, new attitudes toward sexuality, and the breakdown of the extended family. As a result, more young people are sexually active but without adequate information to protect themselves. Often, a double standard prevails about sexual behaviour where it is a virtue for unmarried girls to be virgins while young males are expected to seek sexual adventure before getting married. Fearing that they will be admitting to sexual activity, many young females cannot ask for information about sex or protect themselves and end up exposing themselves to risk of infection. The lack of traditional education on sex and sexuality assumes that the youth will translate the sex knowledge they get from schools into avoidance of unprotected sex. In order to design a program that will ultimately alter behaviour, one must first examine two things: knowledge and attitude. Knowledge of HIV and AIDS may be linked to perception of risk and types of sexual behaviour. For example, in Zimbabwe, a weak association has been found between greater knowledge of HIV and AIDS and a later age at first sex (Gregson et al., 1996). Behavioural change and the link between the subjective perceptions of risk may differ by gender due to gender inequalities. Elias and Heise (1993) suggest that underlying power inequalities may severely limit the ability of many females to change their partner's sexual

behaviour or enforce the use of condoms. In addition, there is much evidence to suggest that females have no control over contraceptive use in relationships, both before and after marriage, as it is the males who control the sexual relations and decision-making. In Botswana, it was found that young females feel at more risk of HIV, and because of cultural expectations to provide sexual satisfaction, are powerless to demand, or indeed negotiate safe sex (UNAIDS, 1992 cited by MacDonald, 1996).

High-risk sexual behaviours, including multiple sexual partners, the use of commercial sex workers, and low condom use are important determinants of HIV transmission. Commercial sex also contributes to HIV infection particularly in the urban areas where unmarried males, or those whose wives live in rural areas, turn to sex workers (Anderson

Caldwell and Caldwell, 1993). In fact, women turn to commercial sex work because of gender inequalities in employment opportunities (Gage and Njogu, 1994). This type of risky sexual behaviour may be especially problematic because condom use is very low. Although sexual networking is acceptable, the discussion of sexual issues was, until recently, a 'taboo'. Such reticence to discuss sexual matters complicates issues, as people may not receive accurate information about HIV and other Sexually Transmitted Infections (STIs).

Changing an individuals' knowledge is relatively easy. As long as information is provided to that individual in a discernable fashion, their knowledge base has changed. For example, if the Department of Road Safety in Botswana were to issue a statement informing a group of previously union formed drivers that it was against the law to drive without wearing a seatbelt, then the knowledge of those drivers will have changed. However, if these drivers are of the attitude that it is ludicrous to wear a seatbelt they may choose not to wear one even though they know that their behaviour is illegal. Therefore, developing a behaviour modification program requires some form of education which includes, and goes beyond, knowledge to affect the attitudes which affect behaviour. McGuire (1973) defines "attitude" as a variable that conciliates between reception and response tendencies. In this context "reception" refers to that predisposition to classify similar stimulus situations into a conceptual category and "response" refers to that predisposition to have a unique reaction to this set of stimuli. Furthermore, there are three aspects of "attitudes" which directly reflect ones' reception and response tendencies:

1. **The cognitive aspect -** involves the intellectual content of an attitude. This may be measured, for example, by a checklist of traits to ascertain an individuals' stereotype of an ethnic group

2. **The affective aspect -** refers to the emotional, evaluative aspect of the attitude which may be measured by a rank ordering of various ethnic groups according to liking

3. **The connative aspect -** refers to the behavioural intentions in the attitude.

McGuire (1973) suggests two ways in which attitude change may occur: firstly, by persuading the individual to re-conceptualise the stimuli so that specific instances are categorized differently and secondly, by altering the individuals' predisposed response to a given group of stimuli. Furthermore, McGuire (1973) supports the notion that there are four communication variables which assist or hamper attitude change: source, message, channel, and receiver. The source can be very influential as long as the receiver is persuaded to believe that it is credible and attractive. The message content and organization can persuade the receiver to respond in a particular way. The channel, be it pictorial, written, or verbal, must elicit responses of attention, comprehension and yielding in order to be effective. Clearly, the receiver is that intervening variable which through source, message, and channel, behaviour modification can be attained.

Suggested methods for altering attitudes and behaviour are numerous. Some follow specific psychological theories, while others follow a general approach. Nonetheless, the overall goal of all the to-be-described behaviour modification programmes is to implement a form of enhancing behaviour while diminishing a form of compromising behaviour. Research shows that well designed programs, which provide information, motivation, and behavioural skills, are effective in delaying adolescents' first intercourse and increasing the proper use of contraceptives/condoms by those who choose to be sexually active (Brown and Eisenberg, 1995; Kirby et al, 1994 as cited in SIECCAN, 1998). Opponents of sex education claim that providing young people with broadly-based sex education will result in the earlier onset of intercourse (McKay, 1993). A number of studies have investigated this issue and there has been no association found between exposure to formal sex education and the earlier onset of sexual intercourse (McKay, 1993). Kirby et al. (1994) concluded, from their extensive review of sex education programs, that including discussions of contraception in combination with other topics do not hasten the onset of intercourse. Empirically-based evidence will be presented to support the implementation of sex education programs, more specifically what programs have shown to be effective in changing the sexual health behaviour of

teenagers. Sexual health behaviour refers to sexual intercourse and the use of contraception, particularly condom usage to prevent pregnancy and HIV and STIs. According to Ellis (1995), there are seven main approaches to behaviour modification in schools: Social Pressure Resistance Skills, Heightened Awareness, Empowerment, Social Skills Development, Psychosocial, Bonding, and Health Belief. Each of these approaches can be implemented to deter risky behaviour and instil abstinence.

2.1 HIV and AIDS Prevalence in Botswana

Heterosexual sex is the main mode of transmission in Botswana. Botswana has for years been listed as the country in the world with the highest HIV infection rate, a record only recently taken over by Swaziland. The internationally widely quote HIV prevalence rates in Botswana, based on pregnant women aged 15-49 years was 38.5 percent in 2000 and 36.5 percent in 2001. However, the 2004 Botswana AIDS Impact Survey conducted by Botswana's Central Statistics Office and the National Aids Coordinating Agency (NACA), working with development partners, found that the national HIV prevalence rate was 17.3 percent. Given Botswana's relatively low population of 1.7 million, the survey's results are believed to be highly representative. However, the national rate of 17.3 percent should not be viewed to provide any form of comfort because HIV prevalence rates are above 30 percent among young adults. The survey also confirmed that among those below 40, the prevalence rate is significantly higher among females than males. Further, rural prevalence is still observed to be on the increase while urban prevalence is stabilising.

"Increase outreach of Voluntary Counselling and Testing for HIV at VT institutions

According to the UN agency dedicated to fight the AIDS epidemic (UNAIDS), national surveys such as the one conducted in Botswana are not necessarily a better measurement of HIV prevalence than surveys amongst pregnant women. In its 'AIDS Epidemic Update 2004', released in November, UNAIDS maintains that "there is no simple and reliable method to assess HIV incidence in sub-Saharan Africa. The closest proxy would be HIV prevalence in 15-24 year-old pregnant women. UNAIDS observes that national population-based or household surveys have advantages and disadvantages, the fact that very many respondents refuse to participate or are absent from the household adds considerable uncertainty to survey-based HIV estimates. The UN specialist agency in its report maintains that HIV prevalence in Botswana exceeds 30 percent, referring to its surveys among pregnant women, compared to 39 percent in Swaziland. The very high HIV infection rates by which the UN operates however have been strongly criticised by an increasing group of specialists. The Austrian specialist of reproductive medicine Christian Fiala has documented that in Africa, AIDS is diagnosed by UN agencies "on the basis of non-specific clinical symptoms and without an HIV test." Tests are therefore "unreliable" and the UN's statistical estimates are "misleading." The researcher especially refers to the "miracle of Uganda", where UNAIDS maintains that HIV rates shrunk from almost 30 percent in the 1990s to 5 percent in 2003, without large-scale programmes to change people's attitudes. Fiala et al (2003) argue that the Ugandan "miracle" simply is based on inflated HIV prevalence reporting by the UN in the 1990s. Regarding HIV prevalence in Botswana, South African Malan (2003) also reserves similar critics. Malan asserts that While UN reports held that Botswana's population was already shrinking due to AIDS deaths, a recent national census showed that the population is growing at about 2.7 percent a year. Malan (2003) is strongly sceptical regarding the UN's use of statistic models and estimations.

All however agree that urgent measures are necessary to meet the AIDS epidemic, no matter if HIV prevalence is at one or at 40 percent. AIDS in any case remains a deadly disease paying a heavy toll on African lives. In 2000, the Harvard Institute for International Development declared that "a frontal attack on AIDS in Africa may be the single most important strategy for economic development." The impact of HIV and AIDS on socio-economic development is already being felt. It is estimated that economic growth, as measured by GDP growth, could be slowed by up to 1.5 percentage points annually. Life expectancy has declined from 65 years to about 56 years as shown by the 2001 national population census. (Centre for Strategic and International Studies (CSIS), 2004) And several health and social indicators, such as infant mortality and maternal mortality, have suffered a reversal. As the pandemic affects mainly those in the most productive years, national productivity has declined. And the workforce in all sectors has been significantly affected (CSIS, 2004).

2.2 Government AIDS Policy

The national policy on HIV and AIDS came into being in 1993. It outlines the national response to HIV and AIDS. Botswana's AIDS policy has evolved from one narrowly focused on blood screening and public awareness programs to what the government now describes as an all-embracing approach. The policy strategies are: prevention of HIV and STI transmission, reduction of

personal and psycho-social impact of HIV and AIDS and STD, mobilization of all sectors, and all communities for HIV and AIDS prevention and care, provision of care and reduction of socio-economic consequences of HIV and AIDS.

Botswana is hailed as a model of the role of leadership in fighting HIV and AIDS. Certainly Botswana would not have made the progress it has without the leadership shown by President Mogae at the highest level. But cadres of leaders at the national and regional levels are also necessary to make the transition from planning to implementation smooth, successful, and rapid. The government's willingness to adopt new approaches has been critical, and leadership among international partners especially willingness to consider flexible and unconventional responses has also been vital to Botswana's success with groundbreaking public-private partnerships.

2.3 Gender Inequality and Culture

Socio-cultural factors that influence men's and women's views on sexuality, their access to information, and their access to health services affect reproductive health and well-being, including the ability to protect themselves against HIV infection. Additionally, in Botswana traditional culture dictates that women have little control over their bodies, and the man is "in control" of the sexual life; women's social position and social attitudes have blocked efforts to empower them to combat and defend themselves against the disease. Early on, HIV and AIDS programmes in Botswana focused on the importance of women in preventing transmission of the disease, especially to children, but the position of women in society means that the real challenges are long term and require cultural change, reform of the legal system, access to education, and economic empowerment. A landmark change occurred early in 2005, when in an outstanding effort to empower women; the Government of Botswana (GoB) approved the Abolition of Marital Power Bill which will abolish the common law rule that gives a husband power over his wife. The passage of the Bill grew out of a 1998 report which looked at all the laws affecting the status of women in Botswana. The report was aimed at expanding the right and thereby enhancing the position of women in terms of the law. Specific laws that were reviewed were the Marriage Act, Married Person's Property Act, Abortion, Penal Code Amendment, Deeds Registry Act, Deserted Wives and Children Protection Act and the Adoption Act. The report also reviewed the extent to which Botswana has complied with UN conventions on women. The Abolition of Marital Power Act will mean, that legally at least, women will have to be part of any decision on joint property and husbands will no longer be able to dispose of property and use the funds without the wife's knowledge and agreement.

With limited access to education and economic resources, women remain apt to fall into transactional sex, for money or status, and often have no choice but to comply with partner's wishes even in very risky situations. Migrancy, also plays a role exposing women to the risk of HIV infection. Some men working in urban areas often have a wife in their village and at least one mistress in the city during the month. Human rights abuses, such as domestic violence, rape and other sexual abuse are potential factors in the transmission of HIV. Other problems include the belief in the traditional healer, with Botswana holding 50 times more traditional healers than medical doctors as the traditional healers are seen as guardians of society and those infected may be more likely to seek this assistance rather than conventional Western medicine (Dyer, 2003). At the same time, interventions focused on women have left men out, as vital actors in preventing HIV and AIDS and in empowering women. It is imperative that HIV prevention efforts should focus on both women and men, emphasizing men's role in preserving their own health and the health of their families. Men are necessary partners in the empowerment of women, and such efforts will have to find ways to work with traditional leaders and power structures. The challenge for GoB and donors is to find effective ways to make socio-cultural issues part of the nationwide war on HIV and AIDS.

Sex Educators and HIV and AIDS Coordinators should be equiped with skills that would enable the learners to develop skills and abilities to be sexually responsible.

2.4 Learners and HIV and AIDS

Learners in training institutions represent a vast human resource potential, which, if properly prepared and tapped can contribute positively to national development. In Botswana, over 60% of the population is under the age of 30 years and 43% is under the age of 15 (GoB, 2004). However, learners' most serious challenges are unemployment, underemployment, and the HIV and AIDS epidemic. Learners in training institutions are particularly vulnerable to HIV infection because of risky sexual behaviour, substance abuse and a lack of knowledge about HIV prevention. Learners are also particularly vulnerable to HIV and AIDS because of the physical, psychological, social, and economic attributes of adolescence. Many learners are economically dependent and socially inexperienced, have not otherwise learned how to protect themselves from infection, and generally have less access to health care than adults. Culture and society have powerful effects on behaviour and often increase learners' vulnerability to HIV and AIDS. Young

Identify and develop central locations where youth congregate and create kiosks or bulletin boards with information about HIV & AIDS and other topics that interest the youth.

learners often are not able fully to comprehend the extent of their exposure to risk and the potentially dangerous results. Botswana is said to have the highest proportion of infected young people, at least one-third of women ages 15 to 24 (CEDPA, 2004).

HIV and AIDS-related education at school and training institutions plays one of the most important parts in educating learners about HIV and AIDS, and Botswana-specific HIV and AIDS materials have been developed for learners with the Ministry of Education. A teacher-capacity building programme has been developed jointly by the Ministry of Education of Botswana and the United Nations Development Programme (UNDP), in collaboration with the government of Brazil and with support from ACHAP. The programme is trying to improve the teachers' knowledge, demystify and destigmatise HIV and AIDS and break down cultural beliefs about sex and sexuality. It is hoped that this will promote free and informative discussions about HIV prevention, living with HIV and AIDS and caring for adults and children with, or directly affected by, HIV and AIDS.

2.5 HIV, AIDS and Poverty

AIDS is now largely a disease of deprivation. A study by the World Bank of 72 countries shows that at the national level both low per capita income and unequal distribution of income are associated with high rates of HIV infection. Among urban adults in the typical developing country, a US$2,000 increase in per capita income is associated with an HIV infection rate 4 percentage points lower (Bell et al., 2003).

In situations of deprivation, young women tend to be at high risk of infection. In many countries young women, lacking opportunities, seek support from men, trading sex-and thus the risk of contracting HIV infection, for security. The risks are greater when the men are older. In Tanzania, for example, where growing poverty has made traditional marriages more difficult to arrange, young women compete for the attention of older men, who are better established than young men and thus more attractive as potential husbands (Mzinga, 2002). Often, this practice is driven by parental expectation of financial support from their children (Mzinga, 2002). Similarly, in Nicaragua economic upheavals have caused many young women to prefer older men who can take better care of them (Leete et al., 2003). In Botswana, young women sometimes enter into relationships with older men, called "sugar daddies" that pay their school fees, buy them gifts, and offer other inducements (GoB), 2003. Economic hardship and civil unrest have pushed more and more young men and women away from home and into towns and cities to look for work. Many enter multiple sexual relationships that carry the risk of HIV and thus transmit the virus from one place to another. Poverty and lack of alternatives also are major reasons that many youth become sex workers and expose themselves to the risk of infection with HIV.

2.6 Stigma and Discrimination Associated With HIV and AIDS

Stigma has been defined as a 'significantly discrediting attribute' and is a common human reaction to disease (Goffman, 1963). Historically, people with diseases like leprosy, tuberculosis, cancer, mental illness and sexually transmitted diseases have been discriminated against and stigmatized but in the latter part of the 20th century, people living with HIV and AIDS have been subjected to the cruellest of discrimination and stigma. Stigma tends to exist in developing nations such as Botswana. Experts also agree that AIDS stigma prevents many people in Botswana from seeking testing and health care. Further, sexually active Botswana learners aged 15-24 report to engaging in unprotected sex because they lack the skills and/or knowledge to obtain condoms and fear recrimination from parents who disapprove of premarital sex. The Ministry of Education (MoE) 2003 Baseline Study on Knowledge, Attitudes and Behaviour of Teachers and Learners towards HIV and AIDS cite unfriendly attitudes of health staff and the lack of privacy in stores that sell condoms, stigma associated with condom purchase as significant "social costs" and barriers to safe sex. The problem is perpetuated by the fact that sex is a forbidden subject in Botswana and those who are associated with HIV are also seen as "dirty" or "immoral." The stigma associated with HIV and AIDS may prove formidable barrier to education efforts and promotes a culture of ignorance regarding HIV among Botswana learners.

The issues discussed show that HIV and AIDS presents many challenges to health education, health services and policies. Attempts to promote behavioural change are key objectives for many AIDS prevention and care programmes. However, approaches should not only focus on a few aspects because AIDS is a complex issue and appropriate AIDS policies and programmes need to take account of the cultural and social context in which individuals experience illness and in which their illness is managed.

[1]Closing Remarks of Donna Shalala. Workplace Conference 2000, "Now More Than Ever: Workplace Solutions for HIV and AIDS." Sponsored by CDC's BRTA/LRTA Programs. September 8, 2000.

3. Methodology

This chapter presents an overview of the methodology and sampling design (adopted at the state level) for carrying out the Baseline Study on Knowledge, Attitudes and Behaviour (KAB) towards HIV and AIDS among learners in the Vocational Training Sector.

The key question in relation to data required is the number of institutions and learners within institutions required for a representative sample, so that findings can be generalized. Issues such as geographical spread and participation criteria have to be considered as they implications for cost. When planning the research, the BIDPA team focused on:

- regional sampling issues
- institutional sampling issues within regions
- within-institution sampling issues (year of study and student numbers)

The research used mixed methodologies of focus groups, and structured interviews. Data for the study were collected using a questionnaire tagged "Knowledge, Attitudes and Behaviour (KAB) Towards HV and AIDS among Learners in the Vocational Training Sector. In order to get a perception of aspects influencing sexual behaviour and gender impact, focus group discussions were conducted. This also facilitated ownership of the study and results by learners.

3.1 Target Respondents and Sampling Procedure

Respondents among learners were defined as those undergoing training in the Vocational Training Sector which includes Brigades, private vocational institutions, and Technical Colleges. From a total of 16000 learners in the Vocational Training Sector, a proportional stratified sample of 1500 learners was selected for structured interviews. The population of learners in the vocational training sector was divided into three strata, viz. Brigades, private vocational institutions, and Technical Colleges. Regional representation was also considered to take into account the heterogeneity in cultural believes and practices.

The participants in the focus groups were selected purposively in the following manner: three groups per institution were selected viz. female only, male only and mixed group of both male and female learners. A common set of questions was developed by the research team. As well, a common framework for the process used in the focus groups was developed and applied by the researchers. The focus groups comprised at most of 15 learners.

3.2 Development of Research Instruments

The BIDPA team developed a structured questionnaire to collect quantitative data from learners. There were three options for administration of the questionnaire: self administration, assisted self-administration or personal interview. The advantages of self administered questionnaires include preservation of confidentiality, and questionnaires are administered in a standard manner. Even though the preferred way was self administration, given the low educational attainment for some of the learners in the Vocational Training Sector, the option for interviews allowed participation by all, even semi-illiterate learners and also gave opportunity for clarification of ambiguity.

The other instrument was a check list to facilitate focus group discussions. These instruments were finalised in consultation with BOTA. Given the complexity of designing a questionnaire, and the issues studied, it is impossible even for the experts to get it right the first time round. The questionnaires were pre-tested - that is, piloted - on a small sample of institutions in Gaborone. Analysis of the responses and the interviewers' comments were used to improve the questionnaire.

3.3 Training of Research Assistants

BIDPA carried out an intensive five -day training of research assistants on issues relating to the study and research methods. The assistants were involved in several studies before similar to this KAB study. Issues discussed during the training included sex and sexuality, condom usage, STDs and HIV and AIDS, interviewing techniques, and a detailed questionnaire briefing. A one-day field visit during the training workshop provided useful insights to each researcher about the approach and field methodology to be adopted for successfully carrying out the study. Mock calls were also undertaken during the training.

3.4 Field Work

Fieldwork was carried out from February to March 2005. Two teams, with one supervisor and two investigators each, were constituted for the North and South part of the country. The north

Learners must be involved in planning, implementation, monitoring and evaluation of programmes targeted at them.

team visited institutions up to Selibe-Phikwe while the south team visited institutions up to Jwaneng. Questionnaires were mailed to institutions in the rest of the country. Focus group discussions were held only at institutions which were visited by the research team.

3.5 Data Processing and Analysis

Quantitative data was entered into a database and analysed statistically using SPSS statistical software. Standard descriptive, cross tabulations and inferential statistics were employed to discover the trends among learners with respect to the indicators measured. Qualitative data from both questionnaires and focus groups was thematically analysed and used to validate the findings of the quantitative survey

3.5.1 Coding

Open-ended questions were coded prior to data entry. Research assistants recorded answers given for each open ended question. Similar responses were given a code. A coding system was then developed and used for entering information from all questionnaires. For quantitative questions, their values were entered as they are e.g. age.

3.5.2 Data Entry and Analysis

Data entry was done through SPSS 12. Data was entered twice using a check file and then the two files were validated against each other. Cross tabulations were used to examine the relationships between socio-demographic variables and knowledge, attitude and behavioural variables.

3.6 Limitations of the Study

The survey targeted a sampled population of 1500 learners, comprised of 507 from 16 Brigades; 487 from 10 private vocational institutions and 506 from 4 Technical Colleges. However, a total of 1297 learners responded to the survey, which makes 85 percent, with 15% non-responses. From a total of 1297, Table 3.0 shows the responses of 1282 learners who highlighted their institutions of learning. It shows that the response rate from Technical Colleges was 100%, Brigades 83% and private vocational institutions 73%.

Non-responses in Brigades were mainly with mailed questionnaires, where two Brigades (Kang and Maun Brigades) failed to return questionnaires altogether. Non-responses in private vocational institutions were a result of a number of factors: not all mailed questionnaires were returned; learner's absences; and because in most cases most institutions were still admitting new entrants, but provided enrolment figures for sampling purposes that included such entrants even though they had not yet started lessons.hen analysing data, the research team experienced some problems which are worth noting. Some learners gave some inconsistencies in responses. For example, some learners would say they never had sex but later would respond that they have used a condom. In such cases, some logical deductions had to be made depending on the answers to several other related questions.

Another problem with the data was missing information. Because of the sensitivity of some of the questions, learners did not answer those questions they felt like not answering. This means that some variables had missing information; in the analysis, missing values are omitted. As a result, the sample size totals change from variable to variable and across tables. In general, however, response rates above 90 % are found for most questions. Also, where the responses are indicated as "Don't know", they are not included in the analysis, unless the "Don't know" has a logical explanation.

Table 3.0: Scope of the study

Type and Number of Institutions	No. Selected	No. Interviewed	% Response
16 Brigades, including mailed institutions	507	421	83
10 Private vocational institutions, including mailed institutions	487	357	73
4 Technical Colleges	506	504	100
Total	**1500**	**1282**	**85**
Mailed Questionnaires			
8 Brigades	212	130	61
1 Private vocational institutions	45	21	47
Total	**257**	**151**	**59**

4. Socio-Demographic Profile of Learners

The chapter describes the socio-demographic profile of learners: an overview of the education and social status of the respondents of the questionnaire. Out of a total of 1500 learners, 1297 learners were interviewed. This represents a success rate of about 90%.

Figure 4.1 Questionnaire administration

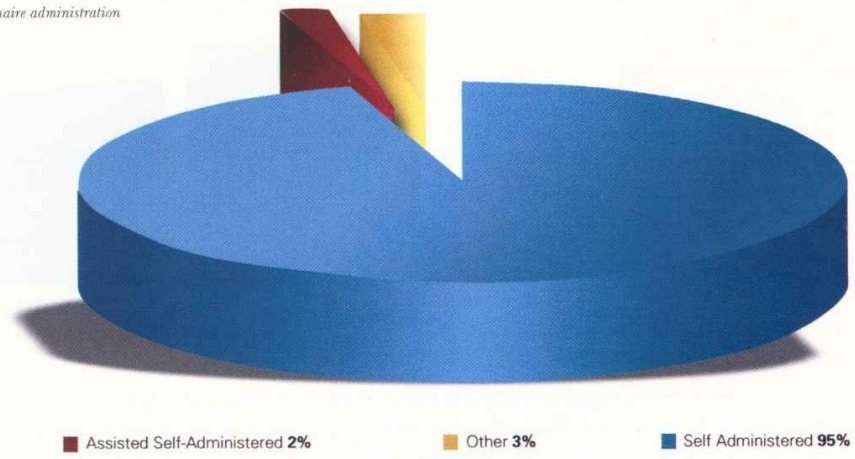


Figure 4.1 above shows the questionnaire administration method. The questionnaire could be filled in as self-administered, assisted self-administered or personal interview. The preferred method was self-administered for reasons already stated in Chapter 3. Out of the 1297 learners that were covered, 1236 learners self-administered the questionnaires (95%), whilst 25 were assisted self administered (2%), 4 learners were interviewed and 32 learners did not indicate, and together this represents 3%.

4.1 Gender, Age and Sexual Orientation

More male learners were covered than female learners in all age groups, except the 17-20 years age group, where an equal number of females and males were covered. In the overall sample of 1297 learners, about 58% were male, and 42% female. This shows that male learners dominate the Vocational Training Sector.

Table 4.1 Learners distribution by age and gender

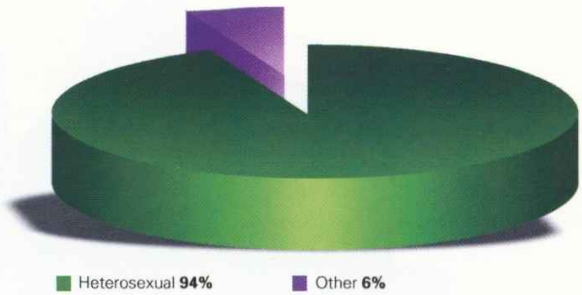
Age in Years	Male	Female	Total	% share
17-20	149	149	298	27
21-25	312	247	559	51
26-30	107	69	176	16
31-35	26	16	42	4
36-40	16	5	21	2
41-54	7	3	10	1
Total	**617**	**489**	**1106**	**100**

The minimum age was 17 years and maximum age was 54 years. The largest proportion of learners is aged 21 to 25 years, which accounts for 51%, followed by the 17-20 age groups, which accounts for 27% and, the 26-30 age group which accounts for 16%. Elderly learners aged 31-54 years were in the minority as they accounted for less than 8% of the total surveyed population.

Private vocational institutions have a large population of learners in the age range of 17 to 23 years, whereas Technical Colleges have a large proportion of learners in the age from 23 and above. In terms of marital status, 91% are single, 5.9% are married, 1.3% is cohabiting, 0.9% is separated and 0.7% is divorced.

Most learners identified their sexual orientation as heterosexual (94%), while others (6%) are 1.5 % as homosexual and 4.5% as bisexual (Figure 4.2).

Figure 4.2: Sexual orientation of learners



4.2 Distribution of Learners by Type of Institutions

The coverage of learners in the vocational training sector is as follows: 32.9% of learners were in Brigades, 25.8% learners from commercial institutions, and 41.3% of learners from vocational institutes. For Brigades and private vocational institutions, 67% and 40.4 were in year 1 respectively. In vocational training colleges 33% were in year 1 and 44% in year 4. Table 4.2 presents the distribution of learners by the type of institution and sex of learners.

Table 4.2 Vocational training learners covered by the survey per institution (%)

	Male	Female	Total
Brigades	64.3	35.7	100
Private vocational institutions	41.3	58.7	100
Technical Colleges	64.5	35.5	100

The Brigades and Technical Colleges dominated by male learners with 64.3% and 65.4% respectively. Private vocational institutions tended to enrol more female with almost 59% of learners being female in private vocational institutions compared to 35% in Brigades and Technical Colleges.

The same picture is depicted between rural and urban areas, except that rural areas do not have private vocational institutions and Technical Colleges. Table 4.3 below shows that the majority of male learners are found in Brigades in both urban and rural areas. Technical Colleges in urban areas have more male learners (66%) than female learners (34%).

Table 4.3 The rural-urban distribution of learners (%)

	Rural			Urban		
	Male	Female	Total	Male	Female	Total
Brigades	56.6	43.4	100	66	34	100
Private vocational institutions	0	0	0	39.5	60.5	100
Technical Colleges	0	0	0	66	34	100

What implications does this pattern have for the future of the learners in the vocational training sector? While female learners have the opportunity of understanding business operations through commercial training programmes, they also need to acquire vocational skills that they can use for income generation

4.3 Learner's Knowledge and Perception of HIV and AIDS

The following section deals with the awareness, knowledge, attitudes and perceptions of the learners related to HIV and AIDS. To what extent are knowledgeable vocational training sector learners engaging in protected sexual intercourse? Are there gender differences in the involvement in protected sex? Are there gender differences in the extent of involvement in protected sex based on the amount of knowledge of how a person can prevent transmission of HIV? The study included questions about their sexual orientation, past and present sexual practices as well as sources of information about HIV and AIDS. The summary about the information sources where the learners have received the relevant information from and which information channels are most available will be made.

4.3.1 Awareness of HIV and AIDS

The findings show high levels of awareness of HIV and AIDS issues among the majority of learners in all institutions. The learners were asked what HIV and AIDS was; what are its symptoms; what causes AIDS; how it is transmitted and spread (see Table 4.4).

Table 4.4 Percentage Share of learners who responded correctly to the question

	TC[1]	Brigades	Private VI[2]
	Percent (%)		
AIDS is caused by HIV	97	96.5	97
HIV is transmitted through blood, semen, vaginal fluids, and breast milk	95	96	98
HIV is commonly spread by having unprotected sexual intercourse with someone infected with the HIV virus	98	99	99
HIV is commonly spread by sharing needles or syringes with someone who has the virus	91	88	93
HIV is commonly spread by getting HIV-infected blood, semen, or vaginal secretions into open wounds	96	94	93
HIV can also be passed from infected pregnant woman to her unborn baby during pregnancy, birth and breast milk	98	97	99
HIV is not transmitted by simple casual contact such as kissing, sharing water glasses, or hugging	83	84	81

[1] Technical Colleges [2] Private Vocational Institutions

The level of awareness was highest, over 90 percent, among learners in all institutions with the exception to the statement that HIV is not transmitted by simple casual contact, such as, kissing, sharing water glasses and hugging. About 16% of Brigades, 19% of private institutions and 17% of VTC learners disagree with the above statement. Such misperceptions about HIV and AIDS were also noted, with student's response to the statement, "AIDS is the most advanced stage of HIV", where 18% of Brigades, 13% of VTC and about 6% of private vocational institutions learners disagreed. Data shows that the majority of those who held such misperceptions about HIV and AIDS are mostly new entrants (or first year learners), particularly male learners, in all three training institutions.

Table 4.5 Regional disparities in knowledge about HIV (%)

	Gaborone	South East	South	Kweneng	Central	Western	Northern	North East	Kgatleng
AIDS caused by HIV	96.7	93.4	98	100	97.5	95.2	100	88.2	100
HIV transmitted through blood	96	96.3	96.8	100	94.8	95.2	100	96.9	97.1
HIV spread by having unprotected sex	99.2	97.6	96.9	100	98.5	100	100	100	100
HIV spread by sharing needles	92.1	83.5	93.7	82.3	87.9	90.4	87.5	90.6	97
HIV spread by getting HIV-infected blood	94.7	92.8	95.7	97.1	95.5	90.5	100	90.3	96.9
HIV passed from infected pregnant woman	98.1	95.1	98.7	100	97.4	100	100	90.6	97
HIV not transmitted by simple casual contact such as kissing	82.6	84.3	83.3	91	83.7	85.7	75	69.7	90.6

Majority of learners in all the regions have information about the modes of HIV transmission. In the North East and Northern regions, about 30% and 25% of the learners respectively have to be educated and informed that HIV cannot be transmitted by simple casual contact such as kissing, sharing glasses or hugging (Table 4.5).

This information is vital because it reduces issues of discrimination and stigmatisation. Most learners, about 99%, know that HIV is spread by having unprotected sexual intercourse with someone infected with the HIV virus.

All learners in Kweneng, Western, Northern, North East and Kgatleng regions possess this knowledge. With this knowledge, learners can act responsibly and use protection when having sexual intercourse. From the table above, it is shown that those learners in Kweneng, Northern and Kgatleng regions are more informed on the modes of HIV transmission.

Ulla Tschoetschel (former BOTA HIV and AIDS Coordinator) holding a focus group discussion with VT learners.

Table 4.6 Which of the statements describe HIV (%)

	Rural	Urban
AIDS is caused by HIV	96	97
HIV is transmitted through blood, semen	98	96
HIV is commonly spread by having unprotected sex	99	99
HIV is commonly spread by sharing needles or syringes	87	91
HIV is commonly spread by getting HIV-infected blood, semen	94	94
HIV can also be passed from infected pregnant woman to her unborn baby	97	98
HIV is not transmitted by simple casual contact such as kissing	84	83

About 99% of the learners in both regions know that HIV is commonly spread by having sexual intercourse with someone who has the virus. On the modes of HIV transmission, there is slight variation in knowledge about these in both rural and urban areas. Only a handful of learners in both rural and urban areas have misconceptions about HIV (Table 4.6).

4.3.2 Gender Disparities in Awareness about HIV and AIDS

While learners were generally knowledgeable about HIVAIDS, it was determined there was still some disparities between male and female learners as well as rural-urban split in awareness levels about HIV and AIDS. The incidence of misconceptions about HIV and AIDS was higher for males than females. Risk perceptions of HIV and AIDS are also varied by region or location of institution. From focus group discussions, both female and male learners in rural areas perceived themselves to be at lower risk than urban learners and did not see HIV and AIDS as a major problem. It also emerged from focus group discussions that urban male learners saw themselves as being at lower risk than rural male learners because of their greater experience and sophistication. In general, Female learners seem more knowledgeable about HIV and AIDS than male learners. There are disparities in knowledge about HIV and AIDS issues between male and female learners (Table 4.7)

Table 4.7 Gender comparison in knowledge level about HIV and AIDS (%)

Which of the following statements describe HIV?	**Male**	**Female %**
AIDS is caused by HIV.	96.2	97.0
HIV is transmitted through blood, semen, vaginal fluids, and breast milk.	95.7	96.1
HIV is commonly spread by having unprotected sexual intercourse with someone infected with the HIV virus.	98.6	99.1
HIV is commonly spread by sharing needles or syringes with someone who has the virus.	88.7	92.5
HIV is commonly spread by getting HIV-infected blood, semen, or vaginal secretions into open wounds.	95.1	93.2
HIV can also be passed from infected pregnant woman to her unborn baby during pregnancy, birth and breast milk.	96.2	99.3
HIV is not transmitted by simple casual contact such as kissing, sharing water glasses, or hugging.	82.8	83.5

Knowledge about transmission routes, and the signs and symptoms of sexually transmitted infections is high, for both females and males. General awareness about HIV and AIDS in particular is slightly higher but specific knowledge about transmission routes and preventive strategies is slightly low for both female and males.

Table 4.8 Regional disparities in knowledge about AIDS (%)

	Gaborone	South East	South	Kweneng	Central	Western	Northern	North East	Kgatleng
AIDS is short for acquired Immune Deficiency Syndrome	98.3	98.9	96.9	100	98.5	100	100	97.3	97.3
It is the most advanced stage of HIV infection	91.2	80.9	79.2	96.4	85.3	93.7	80	81.5	76.7
None of the above	9.9	8.6	11.5	5.3	10.2	0	9.1	0	12.5

All the learners in the Kweneng, Western and Northern regions know that AIDS is a short form for Acquired Immune Deficiency Syndrome. However, not all learners in South East (81%), Kgatleng (76%), Southern 79%), and North East (81%) know that AIDS is most advanced stage of HIV infection (Table 4.8)

4.3.3 AIDS and its Symptoms

Table 4.9 below shows that most learners in both rural and urban areas know that AIDS is a short form for Acquired Immune Deficiency Syndrome. Only a few, about 9% have no idea about what AIDS stand for in both rural and urban areas.

Table 4.9 Which of the following statements describe AIDS (%)

	Rural	Urban
AIDS is short for Acquired Immune Deficiency Syndrome	98	98
It is the most advanced stage of HIV infection	84	88
None of the above	9	9

Most learners in the Western and Northern regions know more about the symptoms of HIV and AIDS than the rest of the country (Table 4.10). The least knowledgeable learners about symptoms of HIV and AIDS are found in the Northeast and Kgatleng regions especially with regard to recurring fevers and/or night sweats.

Table 4.10 What are the symptoms of HIV and AIDS (%)

	Gaborone	South East	South	Kweneng	Central	Western	Northern	North East	Kgatleng
Rapid loss of weight	96.9	94.5	96.9	100	94.7	100	92.8	94.4	100
Long-lasting Diarrhoea	96.2	83.7	97.8	93.7	98	100	100	84.4	91.2
Recurring fevers and/or night sweats	91.2	80.5	95.4	84.8	87	100	100	65.6	78.6
Recurring or unusual skin rashes	96.8	92	97.8	96.9	95.3	100	100	81.2	100
Loss of muscular strength	91.7	86.5	100	87.9	90.6	94.7	100	84.4	83.3

Table 4.11 What are the symptoms of HIV and AIDS (%)

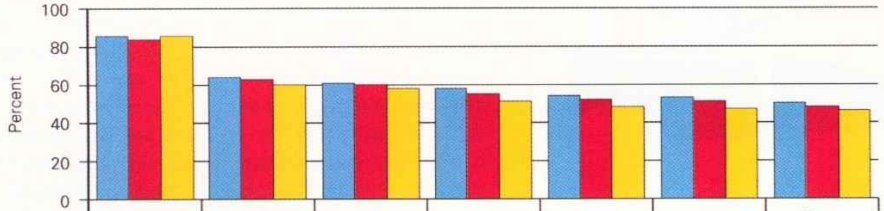
	Rural	Urban
Rapid loss of weight	97	96
Long-lasting diarrhoea	94	96
Recurring fevers and/or night sweats	80	90
Recurring or unusual skin rashes	92	96
Loss of muscular strength	87	92

Most of the learners in both rural and urban areas have knowledge on the symptoms of HIV and AIDS (Table 4.11).

4.3.4 Sources of Information about HIV and AIDS

Learners obtained information about HIV and AIDS primarily from the media rather than from school classrooms and homes, which suggests a need to increase educational efforts in institutions of study. HIV and AIDS coordinators must go beyond providing accurate information about HIV and AIDS; they must also help learners realistically assess their own risk of infection, and develop communication processes which enable them to negotiate safer sexual practices. All learners from the three types of institutions depicted a similar pattern of where they source information on HIV and AIDS issues. A high percentage, over 80%, of learners across the three institutions gets information about HIV and AIDS from television. This is followed by parents and magazines at around 60%, friends, relatives, teachers and peer educators in that order.

Figure 4.3 Sources of information on HIV and AIDS by institution type

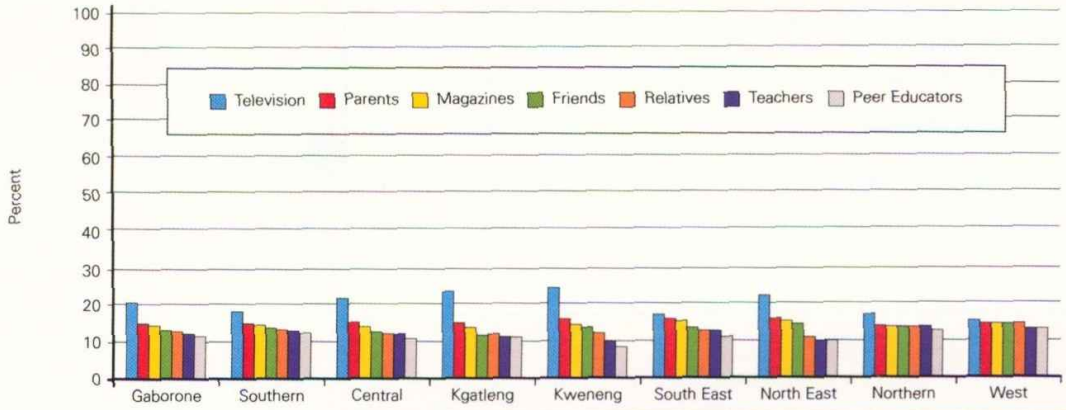


	Television	Parents	Magazines	Friends	Relatives	Teachers	Peer Educators
Technical Colleges	86	64	61	58	54	53	50
Brigades	84	63	60	55	52	51	48
Private Vocational Institutions	86	60	58	51	48	47	46

Teachers and peer educators provide information to about half of learners in all three types of institution, and come out as the least, but significant, source of information on HIV and AIDS. In focused group discussion, learners did not only observe that guidance and counselling teachers are not very knowledgeable about HIV and AIDS issues, but hardly address them on HIV and AIDS issues, nor present in their offices if learners seek their help. HIV and AIDS Peer Educations Groups were reported to be new, inactive or dormant. This suggests that periodic workshops to coach both counsellors and peer education groups on HIV and AIDS issues are needed. In addition, the availability of television programmes, institutional videos, and pamphlets on HIV and AIDS in all vocational training institutions can go a long way in improving the awareness levels about HIV and AIDS, and provide valuable policy intervention measures to that regard.

Sources of information on HIV and AIDS may vary according to region depending on the level of media penetration and centres where learners can get information.

Figure 4.4 Sources of information by region



From Figure 4.4, it is evident that in all the regions, most learners rely on television as a source of information on issues of HIV and AIDS. In the Western region, there is not much of difference between television and other sources of information though.

We also investigated whether there are any rural-urban disparities and in sources of information. Figure 4.5 shows that television sources of information are favoured above other sources for both rural and urban areas. The high rating of this item shows that the idea of media has penetrated the public domain to a significant extent and that the idea is well received.

Figure 4.5 Sources of information by rural areas

Television **21%**
Parents **15%**
Magazines **14%**
Friends **13%**
Peer Educators **12%**
Teachers **13%**
Relatives **12%**

Parents were ranked second after broadcasting media as HIV and AIDS information resources in rural areas. In urban areas parents and relatives are also ranked as second sources of HIV and AIDS information (Figure 4.6). It is encouraging to see that barriers of past years that made it difficult for parents to talk to their children on issues of sex and sexuality are easing for the better. It becomes evident that learners in rural areas believe that within their immediate social environment there is sufficient information available to address their unanswered questions about HIV and AIDS.

Figure 4.6 Sources of information in urban areas

Television **20%**
Parents **15%**
Magazines **14%**
Friends **13%**
Peer Educators **11%**
Teachers **12%**
Relatives **15%**

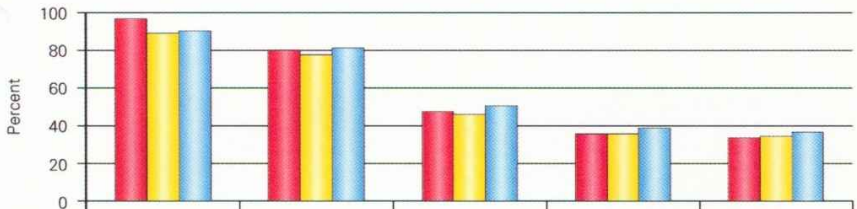
Teachers and friends are ranked fourth for rural areas while only friends are ranked fourth for urban areas with teachers ranked fifth. Although teachers and friends seems to be the least source of HIV and AIDS information, they are to about 50% of learners, figure 4.3, thus suggesting that improving their skills of sharing HIV and AIDS issues with one another can improve the efficiency of counsellors and peer education in imparting knowledge that can change attitudes and behaviour regarding HIV and AIDS. The least favoured source of information in rural areas is relatives and peer educators while for urban areas it is teachers and peer educators. It is troubling that in the rural areas, schools are apparently not widely considered as sources of HIV and AIDS information dissemination and discussion, especially since these are also the most under-resourced in terms of penetration by other media.

4.3.5 Ways of Avoiding HIV Infection

HIV is transmitted through several routes. Among the most prevalent of them are: having unprotected sexual intercourse with an infected person; sharing needles for injecting drugs with someone already infected; tattooing, body piercing or acupuncture with unsterilized needles; receiving infected blood or blood products; and, during pregnancy, at birth or through breastfeeding, an infected mother passing the virus to her child.

Respondents were asked whether they knew anything that a person could do to avoid contracting HIV and AIDS and a list of options was provided. Results are shown in Figure 4.7 show that the majority of learners, over 95% are very knowledgeable about ways to avoid getting infected with HIV. Abstinence was correctly picked by the majority of learners, at least 90%, as the top means by which a person can do to avoid getting the virus that causes AIDS. Condom use was the second top means, selected by about 80% of learners, by which one could prevent getting infected with HIV. Third choice was sticking to one partner, selected by about 50% of learners, and followed by avoiding sex with prostitutes and many partners. However, it is important that HIV and AIDS lessons in vocational institutions should encourage the use of condoms, sticking to one partner, avoiding sex with prostitutes and avoiding many partners, as these are very vital and relevant in the fight against the disease. Abstinence should also be encouraged, but it should not be the absolute strategy as it cannot be sustained.

Figure 4.7 Ways of avoiding infection



	Abstinence	Use Condoms	Stick to one partner	Avoid sex with prostitutes	Avoid many partners
Brigades	97	85	49	37	35
Vocational Training Institutions	90	78	47	37	36
Technical Colleges	91	81	51	39	38

Only few learners, about 2% in Brigades, and 1% in private vocational institutions and Technical Colleges harbour some misperceptions about HIV and AIDS, as they are of the view that avoiding mosquito bites can help one to avoid getting infected with the virus that leads to AIDS. Overall this suggests that the level of awareness about HIV and AIDS issues in vocational training institutions is very high.

4.4 Sexual Behaviour and Attitudes

In this section we look at the sexual intercourse experience of respondents and consider the levels of current sexual activity. The practice of sexual intercourse, its onset and frequency, are important predictors of HIV exposure risk. In Botswana there is a tendency to equate sex with intercourse alone. This represents long-standing cultural norms of acceptable sexual behaviour. It also reflects a deeply rooted ambivalence about talking about sex. Strategies to combat HIV and AIDS, however, are forcing a reappraisal of the implications of this exclusive focus on coitus for research and data collection efforts, for HIV prevention, and for the framing and interpretation of abstinence and risk-reduction messages. Given that sexual intercourse is the main transmission method for HIV in Botswana, information on the onset of sex can assist in designing campaigns that focus on decision making in relation to sexual onset; that is with a view to delaying the onset of sexual intercourse.

Workshops are part of the consultation process

4.4.1 Sexual Activity

HIV and AIDS has brought a new examination of what having sex means, especially among young people. How learners define having sex is important because it helps determine whether they consider themselves to be at risk, how they respond to HIV-prevention efforts, and how they report sexual experience in surveys. Studies generally have considered people as sexually active only if they are having vaginal intercourse. Sexual behaviours such as anal intercourse, however, are not linked to pregnancy but do pose a risk of HIV and AIDS and other STIs.

Table 4.12: Ever had sex before (%)

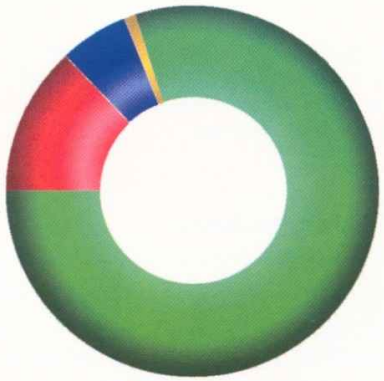
Institution	Response	Male	Female	Total
Brigades	No	14	18	15
	Yes	86	82	85
Private Vocational institutions	No	16	26	22
	Yes	84	74	78
Technical Colleges	No	6	7	6
	Yes	94	93	94
Overall Total	No	11	17	14
	Yes	89	83	86

In this study, many learners reported sexual activity, and from focus group discussions they define sex as vaginal penetration. The following are some notable features of Table 4.12: 86% of respondents had had sex before, and only 14% never had sex. Across all institutions a high percentage of male learners relative to females had had sex before, which is also reflected by a slightly higher percentage of females who never had sex.

4.4.2 Age at First Sex

Age at first sexual encounter is an important risk factor in HIV infection. A further risk factor for female learners revealed through research studies is that in some societies, initiation into sex often involves coercion, increasing the risk of trauma during intercourse and the potential for HIV transmission. Therefore, age at first sex is an important factor to promote HIV prevention practices. It can be assumed that young learners would be likely to engage in sexual activities in contexts quite different to those of older learners, and they are unlikely to have the same means and understanding to negotiate HIV preventive practices, or at least, are likely to approach the problem in different ways. Therefore there is a need to understand sexual activity at different age levels so that appropriate intervention programmes can be designed. Figure 4.9 shows an indication of the age of first intercourse between male and female learners.

Figure 4.8 Reasons for not having Sex



Of the 14% learners who have never had sex before they cited several reasons for not having had sex, among them religious principles as the major reason, followed by HIV and AIDS and health concerns, with culture selected by only a few though (Figure 4.8).

Figure 4.9 Age at first sex for male and female learners

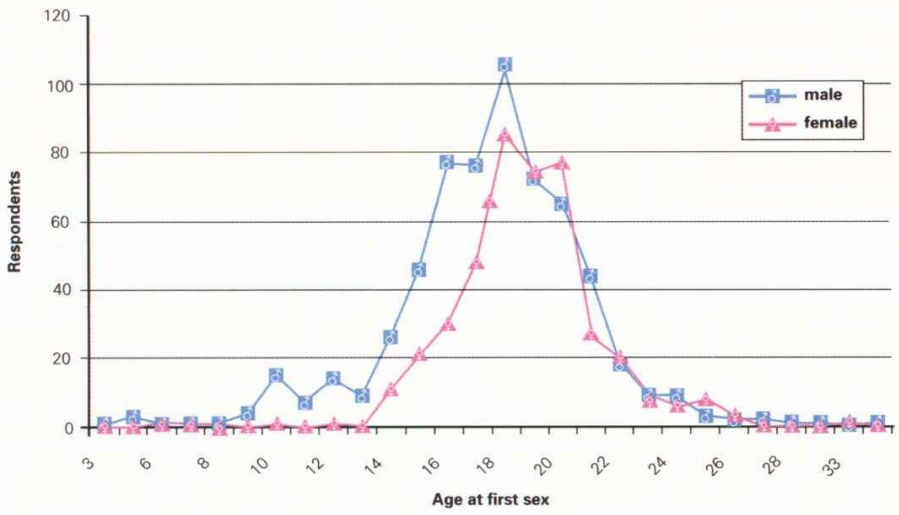


Figure 4.9 shows that, both sexes appear to start seriously engaging in sex from the age of 14 to 23 years, with 18 years being the age for first sex for the majority of learners in all vocational training institutions. Fewer males reportedly started experimenting with sex earlier, before the age of 12 years, which suggests that HIV and AIDS intervention measures should start right from primary schools. Early sexual activity has been a common feature for learners aged 19 to 35 years (see table 4.13). Late sexual activity is observed among learners aged 36 and above. Early sexual activity is high among learners aged 19 years or less, and they constitute a large number of those in the first year and second year of training in vocational institutions. Thus suggesting that institutional HIV and AIDS education efforts should target this age group (less than 19 years), but without necessarily excluding the rest.

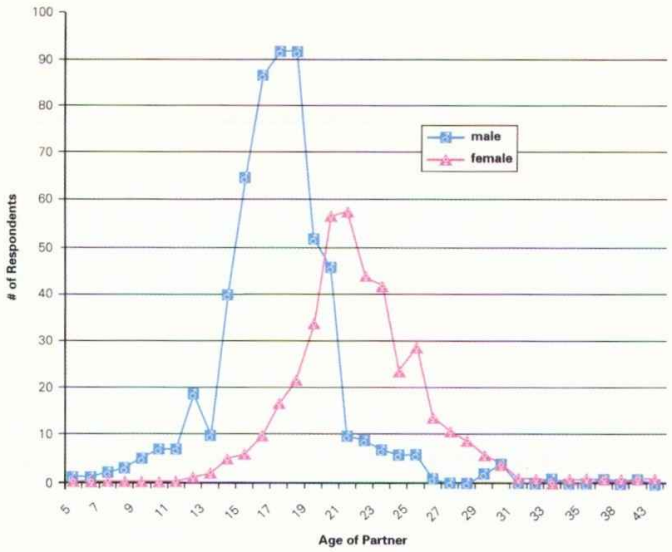
Table 4.13: Age of respondent versus age at first sex in percentages

Age of respondent	Age at first sex				Total
	14-19	20-25	26-30	31+	
≤19	97	3	0	0	100
20-25	70	30	0	0	100
26-30	55	40	4	0.7	100
31-35	66	31	3	0	100
36+	12	82	6	0	100

The majority of male learners had younger partners at first sex, on average a 17 year old female, whereas female learners tended to have older partners at first sex, on average a 21 year old male.

There is inter-generational sex both among female and male learners. This seems more common among female learners, as their male partner age ranged from 16 to 32 years compared to that of males that ranged from 14 to 27 years (see Figure 4.10). A number of studies found that a large number of young females compared to boys tend to be infected with HIV, because of intergenerational sexual partner-ships. In some focus group discussion in Gaborone, learners indicated that there is a lot of commercial sex done by female learners, as a way of dealing with their financial needs. The survey also learnt that in some cases learners face difficulties asking their older partners to use condoms, as it is usually the older partner who makes the decision.

Figure 4.10 Age of partner at first sex



Large economic disparity that exists between partners is associated with intergenerational sex. This situation is not only common to older male partners and younger female partners but also common among older female partners and younger male partners.

Table 4.14: Age at first sex versus age of partner at first sex in percentages

	Age of Partner					
Age at first sex	**14-18**	**19-23**	**24-28**	**29-32**	**33-37**	**38-43**
14-18 male	91	8	1	0	0	0
14-18 female	29	61	7	1	1	1

For female learners, intergenerational sex sets in early, as a few (7%) of those aged 14-18 years, at first sex, had partners aged 24-28 years, and about a percent had partners aged 29-32 years as well as 33-37 years respectively. For a few (1%) male learners the intergenerational sex sets in at the same age as females, 14-18 years, with partners aged 24-28 years. According to Table 4.14, intergenerational sex is more common among female learners to the extent that one percent of 14-18 years old female learners have sexual partners aged in the range of 38-43 years.

4.5 Condom Use among Learners

Male condoms are the primary prevention technology available to protect against HIV transmission during sexual intercourse. While they are very effective when used consistently and correctly, there are many barriers that limit their use. In cultures where condoms are associated with illicit sex and STDs, women who attempt to introduce them into a relationship encounter problems such as being perceived as unfaithful or over prepared. Condom use may conflict with their own, or their partner's desire, to conceive. Among both women and men, barriers to condoms also include perceptions that they reduce pleasure and intimacy, and the fear that suggesting them would insult their partners.

4.5.1 Condom Use at First Sex

This section looks at rates of condom use and examines beliefs and attitudes associated with condom use. There is a generic perception that young people are less likely to use condoms at first sex, even when they do have information because they lack skills to negotiate for condom use, or are too embarrassed to talk with their partner about sex. They also have a tendency of engaging in unprotected sex because they perceive their individual risk as low. From this study though, condom usage was very high at first sex, across gender, particularly among females, and across vocational training institutions (Table 4.15).

Table 4.15: Use of condom at first sex (%)

Institution	Response	Male	Female	Total
Brigades	No	23	4	16
	Yes	77	96	84
Private vocational institutions	No	30	12	20
	Yes	70	88	80
Technical Colleges	No	26	17	23
	Yes	74	83	77
Overall Total	No	26	12	20
	Yes	74	88	80

Table 4.15, shows that 26% of male learners compared to 12% of female learners did not use condoms at first sex. Safer sex usually depends more on the ability to convince partners that it is in their mutual best interests to use a condom, without changing the basis of the relationship. Proposing condom use by women introduces an assertiveness and confidence that sex partners may not welcome. The cited problems associated with the use of female condom are:

Bulky size

Shape not attractive

Uncomfortable to use

Lack of skills to use it

Noisy during sex

Waiting time before use is too long

The outer ring is visible outside the vagina, which can make some women feel self-conscious

It is relatively expensive and relatively limited in availability in some regions

Even though the female condom is not dependent on the male erection which does not interrupt sexual spontaneity learners feel that having to wait after fitting the female condom kills the spontaneity of love making.

Learners expressed their concerns with the unavailability of condoms in their institutions. Male learners indicated that in the event one is lucky and get offered a quickie it is difficult to resist, and one ends up engaging in unprotected sex. In institutions were condoms are distributed, learners complained that there are not placed in convenient places, e.g., in some institutions they are placed in the refectory. In institutions where condoms are distributed, they are not distributed frequently. It is also important to distribute female condoms. The improved distribution and easy access to female condoms by female learners can further equip them to protect themselves from their male partners who may not want to use a male condom. This is because in focused group discussion it was observed that in institutions where condoms are distributed, it is only male condoms that are distributed.

It is important to note that although a high proportion of learners have had sex, the frequency of sexual intercourse is relatively low as a high proportion of those claiming to have had sex have had it months ago. The implications of this data are that in most of the institutions sexual intercourse is intermittent rather than regular and frequent. This is consistent with the focus group discussion which points to the opportunistic nature of sexual contact between learners who are not cohabiting. This to some extent indicates that abstinence messaging may be relevant for those who have ever had sex but have perhaps only had sex once or twice, as opposed to those who are truly sexually active (those who had sex days ago). Therefore, in terms of defining target audiences, the learners should not simply be divided into those who are virgins and those who are sexually active but should include a third category of those who have had sex but cannot be described as sexually active. Accurate identification of target groups is essential for tailoring appropriate messaging on prevention strategies.

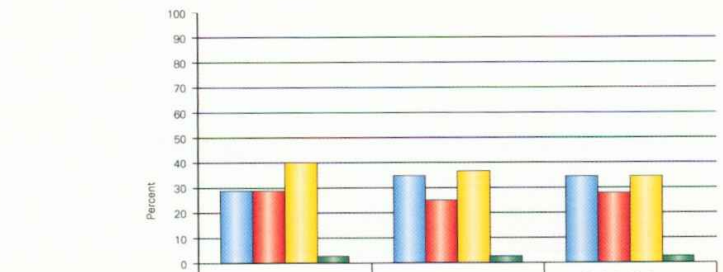
The majority of learners across all three types of vocational training institutions indicated that they always used condoms when they have sex, thus, displaying very positive attitudes towards HIV and AIDS prevention. This suggests that learners are responding well to both the national (for learners in institutions where there are no HIV and AIDS programmes), as well as institutional awareness efforts towards HIV and AIDS. A deliberate move to introduce HIV and AIDS awareness programmes in institutions will further consolidate the positive progress achieved so far. This could further reverse the attitudes of those who use condoms "some of the time" (Figure 4.12) or "never" use them at all, and help prevent the spread of the disease to other learners.

4.5.2 Sex Frequency and Regularity in Condom Use

In this section we attempt to measure the impact upon behaviours that are logically related to HIV infection by frequency of sexual activity, number of sexual partners and condom use.

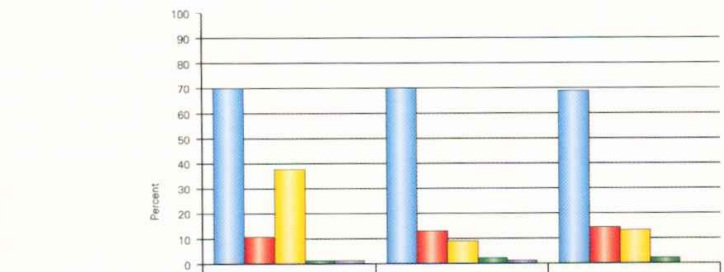
We used information on recent sexual activity to measure exposure to the mentioned risks. All the respondents who reported that they had ever had sex were asked how long ago they had last had sexual intercourse. When learners were asked about the last time they had sexual intercourse they responded in ways that suggests that they engage in sexual activity more often, and with the frequency high among learners in private vocational institutions and Technical Colleges compared to Brigades learners (Figure 4.11 below).

Figure 4.11 When was the last time you had sex



	Brigades	Vocational Training Institutions	Technical Colleges
Days ago	29	35	35
Weeks ago	29	26	28
Months ago	41	36	35
More than a year	2	2	2

Figure 4.12 Did you use a condom when you had sex



	Brigades	Private Vocational Institutions	Technical Colleges
Always	75	75	69
Most of the time	12	14	15
Some of the time	10	9	14
Never	1	2	2
Don't know	1	1	0

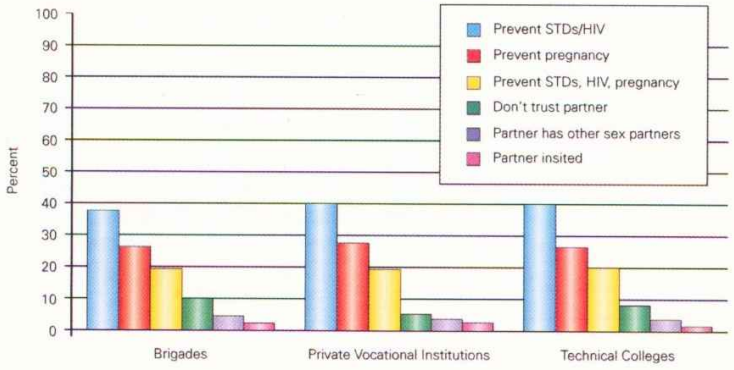
The rate of condom use amongst sexually active learners is relatively high. It is disturbing to note that the lack of availability of condoms is a key constraint to use amongst learners. Increasing access to condoms in institutions and in learner friendly outlets must be considered to reduce the incidence of unprotected sex amongst learners.

From Table 4.16, the majority of learners, about 89 percent, indicated that the last time they had sex they used condoms. The majority of Technical College learners, about 91 percent of both sexes used condoms the last time they had sex. In Brigades and private vocational institutions the majority used condoms the last time they had sex, but females had a slight edge above males. About 11 percent, of which 12% are males and 10% females did not use condoms the last time they had sex. Given that only 5.9 percent reported to be married, this suggests that about 5% of learners across institutions engaged in unprotected sex. Only few learners, 56 in total, responded to the question that wanted to establish the reasons why they did not use a condom the last time they had sex. Of these, majority was male, and is of the view that sex is more enjoyable without a condom.

Table 4.16 Did you use a condom the last time you had sex (%)

Institution	Response	Male	Female	Total
Brigades	No	15	9	13
	Yes	85	91	87
Private vocational institutions	No	14	11	12
	Yes	86	89	88
Technical Colleges	No	9	9	9
	Yes	91	91	91
Overall Total	No	12	10	11
	Yes	88	90	89

Figure 4.13 Reasons for using condom last time you had sex



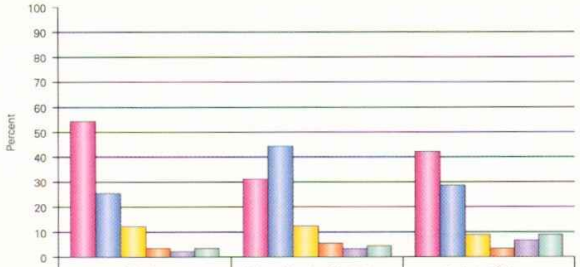
Preventing sexually transmitted diseases, HIV and pregnancy are the main reasons learners who engage in sex gave for using condoms. The other factors such as not trusting one's partner, partner having other sexual partners, and partner insisting on using condoms rated least (Figure 4.13).

4.5.3 Relationships and Sexual Practices

Relationships lasting anything up to a year are relatively common. Steady relationships (with or without sex) are much more common than casual (sexual) relationships and provide a better opportunity for frank discussion between partners on HIV prevention strategies.

Figure 4.14 Relationship with person you last had sex with

The majority of learners indicated that they last had sex with their boyfriends, girlfriends, and partners (Figure 4.14). In Technical Colleges less than 10% of learners, indicated that they last had sex with their wives and husbands, a percentage slightly more than those in Brigades and private vocational institutions. This suggests that there are more elderly and married learners in Technical Colleges compared to Brigades and private vocational institutions.



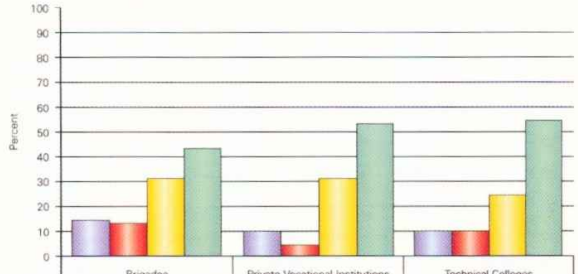
	Brigades	Private Vocational Institutions	Technical Colleges
Girlfriend	54	31	42
Boyfriend	25	44	29
Partner	12	12	9
Casual acquaintance	3	5	3
Wife	2	3	7
Husband	3	4	9

Information was collected for casual partners. Casual partners are defined as a casual acquaintance the learners are not going steady with once or more times. This was meant to measure high risk sexual activity. All the respondents were asked whether they had any casual relationships and the results show a small number of learners across institutions are engaging high risk sexual activity.

What emerges from Figure 4.15 is that the majority of learners across institutions had sex with people they had known for months or longer. However, at least 10% of learners had sex with those that they had known days or weeks ago, which could suggest a high exchange rate of partners in this group.

Figure 4.15 Length of time you have known the person you had sex with

The casual partner in the given meaning is a one-night and short-term partner. The lower rate for the given indicators shows that a small percentage of learners engage in this type of risky behaviour.

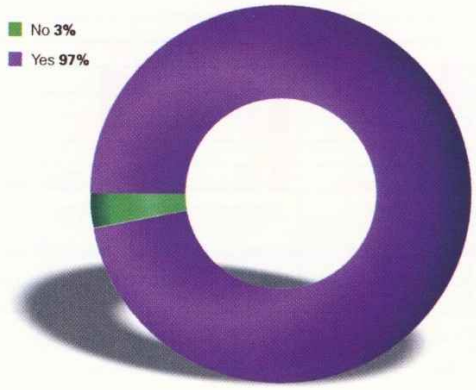


	Brigades	Private Vocational Institutions	Technical Colleges
Days ago	14	10	10
Weeks ago	13	5	10
Months ago	31	31	25
Years ago	43	54	55

4.5.3.1 Decision Making in Relationship

The concepts of sexual negotiation and decision making are not only important in relation to HIV and AIDS; it is a serious concern that there still are people who have forced sex. In contexts where there are significant power differentials between partners, the less powerful partner is liable to be manipulated or coerced. There has been much written about the gender dynamics of such coercion, with women having been shown in many societies not to be in a position to assert themselves in sex contexts, or to make choices about sexual participation. A question asked whether learners agreed to have sex or not. In response, 97% of learners said they agreed to have sex (Figure 4.16).

Figure 4.16 Did you agree to have sex



Only a small percentage of learners indicated that they did not agree to sex (3%).

Only a small percentage of learners indicated that they did not agree to sex (3%).

Table 4.17 Gender and decision making about sex (%)

	Did you agree to have sex?		
Gender	**No**	**Yes**	**Total**
Male	**3**	**97**	**100**
Female	**3**	**97**	**100**

Table 4.17 shows that there is no difference between male and female learners in decision making about sex. The same percentage of learners across male and female learners agreed to sex and did not agree to participate in sex respectively. However, when learners were asked if they agreed with the statement: "Sometimes I have sex even though my girl/boyfriend/partner/ wife or husband does not want to"; majority (over 75% of male learners and 80% of female learners) across institutions answered: No. Suggesting a significant percentage of male learners, over 20% across institutions (and about 20% for female learners) will have sex with their girl/boyfriend/partner/wife or husband even when they do not want to (see Table A 4.0 in appendix A). Female learners are in the majority of those who will not insist on having sex if their partners, boyfriend or husband says no to sex. Thus, suggesting conformity with culturally expectations, as females, are not usually expected to insist on having sex. But an encouraging high percentage of male learners will also not insist on having sex if their girlfriends, partners and wives do not want. But an equally high number of males, up to 25% in private vocational institutions will still have sex with their partners and girlfriends even when they insisted on not having sex (see Table A4.1). This suggests that in a number of instances males still dominate their female partners on making decisions to have sex.

On a follow up question, learners were asked if they agreed or disagreed with the following statement: "If my girl/boyfriend/wife/husband/partner says no to sex, I accept it." The majority across gender and institutions agreed with the statement, particularly females. Again, 11% of male learners in Brigades, 17% in private vocational institutions and 13% in Technical Colleges disagreed with the statement, compared with 5% Brigades and private vocational institutions females, and 7% learners in Technical Colleges (see Table A4.2, in appendix A). This further suggests that in a minority of cases male learners still dominates female learners in decisions relating to sex. It is further encouraging noting that in the majority of cases the decision to have sex is undertaken by both partners.

4.5.3.2 Reasons for Having Sex

From Figure 4.17, reasons that influenced learners to have sex are in their order of highly selected as follows: enjoyment of sex; love partner; for fun; married; fear of what friends will say; seeking marriage, fear of losing partner, and forced. This suggests that the majority of learners engage in sex for recreational purposes, and only a few, particularly boys engage in sex due to peer pressure.

About 2% of learners in private vocational institutions cited force as the reason for having had sex. Only 34 learners (or 3%) out of 1297 learners surveyed, had sex because they fear what their friends will say if they don't, male learners account for (74%) but this kind of peer pressure does not seem to dominate for female learners. More males also reasoned that they have sex for fun and because they enjoy it (Table 4.18). Surprisingly for those who cited money, force and seeking marriage as reasons for having sex, all of them are male learners.

Figure 4.17 Reasons for having sex

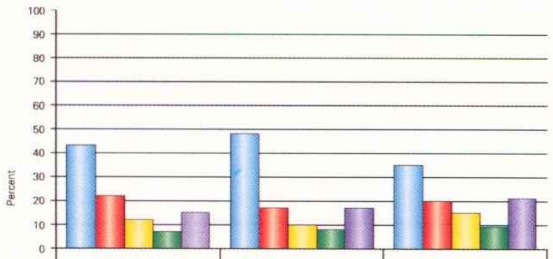
Table 4.18 Reasons for having sex (%)

	Fear of what my friends will say if I don't	I enjoy it	For fun	Seeking marriage	Money	Forced
Male	74	65	63	65	100	100
Female	26	35	37	35	0	0

4.5.3.3 Number of Sexual Partners

The risk factor of having multiple sex partners was also considered. The number of sexual partners learners ever had is 3 to 5 when considering the median and the most common number is 1 or 2 partners. Number of sexual partners learners ever had in the past year is 1 or 2 when considering the median and the most common number of partners is 1 or 2. Figure 4.18 shows that over 45% of learners, across institutions, had only one partner during the past year. This corroborates 50% of learners who picked sticking to one partner as a way of preventing HIV infection. Over 20% of learners across the three types of institutions had two partners in the last year. All this suggests to some degree that the public education awareness programmes on issues of HIV and AIDS, particularly the one encouraging people to stick to one partner is bearing fruit. However, there is a need to maintain the momentum, and keep such awareness programmes going, so as to convert the few learners who still have a high exchange rate of partners, as reflected by the percentages of those who had over three partners in the last year in Figure 4.18.

Figure 4.18 Number of sexual partners you ever had



	Brigades	Private Vocational Institutions	Technical Colleges
One or two	43	48	35
Three or five	22	17	20
More than ten	12	10	15
6 or ten	7	8	9
Don't know	15	17	21

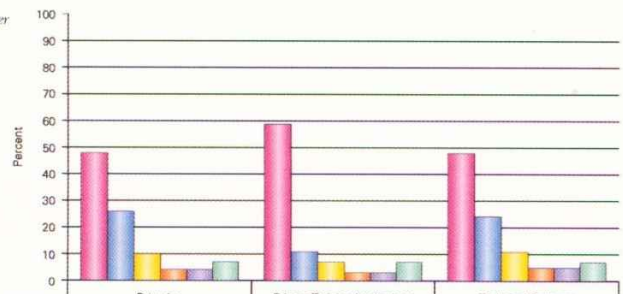
From Figure 4.18, the majority of learners indicated the number of sexual partners they had last year or ever had as one or two, about 20% of learners had three or five, at least 10% of learners had over ten partners, less than 10% had six to ten partners. However, about 15% of Brigade learners, 17% of private vocational training institutions and 21% of Technical College learners, did not know how many partners they ever had, suggesting that they could have lost count.

There is a strong difference between men and women with respect to the likelihood of having more than one partner. Females have a much stronger tendency to have more than one sexual partner and this tendency needs to be addressed in HIV and AIDS education efforts. Females reported a larger number of partners than males when considering the median (Table 4.19)

Table 4.19 Number of sexual partners

	Male		Female	
	Number of sex partners you ever had	Number of sex partners in the past year	Number of sex partners you ever had	Number of sex partners in the past year
Median	1 to 2	1	3 to 5	2
Mode	1 to 2	1	1 to 2	1

Figure 4.19 Number of sexual partners you had last year



	Brigades	Private Training Institutions	Technical Colleges
One	48	59	48
Two	26	21	24
Three to five	10	7	11
five to seven	4	3	5
more than seven	4	3	5
Don't know	7	7	7

Figure 4.19 shows that having one partner dominate across all learners in all institutions with about 50% of learners in Brigades and Technical Colleges having had one sexual partner in the past year and almost 60% of learners in the private vocational institutions having had one sexual partner. However, 26% and 24% of learners in Brigades and Technical Colleges respectively have had 2 partners in the past year compared to 21% of learners in private vocational institutions (Figure 4.19).

Table 4.20 Number of partners you ever had (%)

	Number of sex partners you ever had					
	One or two	Three or five	Six or ten	More than ten	Don't know	Total
Male	34	19	9	17	21	100
Female	54	21	7	7	13	100

Table 4.20 indicates that more females tend to have 1 to 5 sexual partners than males. In contrast males dominate in having 6 to ten or even more partners. More male learners (21%) do not know how many sex partners they ever had.

4.5.3.4 Trust in Relationships

The issue of trust in a relationship and steady partners versus casual partners has been explored since differences in how a partner is classified are likely to effect issues of trust which relate to sexual behaviour, especially condom use. Respondents were asked if they think their partner has other partners. Table 4.21 shows that about 41% of learners in all institutions do not know if their partners have other sexual partners, and about 29% believe that their partners are cheating with other partners. This suggests that although the majority of learners had one partner over the past year, they did not trust that their partners were not cheating on them. Only 30%, of learners trusted their partners not to cheat on them, the majority of which were female learners.

Table 4:21 Do you think your partner(s) have other sexual partners (%)

Institution	Response	Male	Female	Total (%)
Brigades	No	26	35	30
	Yes	33	23	29
	Don't Know	40	42	41
Private vocational institutions	No	25	44	36
	Yes	30	19	24
	Don't Know	45	36	40
Technical Colleges	No	26	28	27
	Yes	34	25	31
	Don't Know	39	48	42
Overall Total	No	26	35	30
	Yes	33	22	29
	Don't Know	41	42	41

More females seem to trust that their partners compared to male learners as 35% female learners do not think their partners have other partners compared to 26% of male learners (Table 4.22). However, more female learners (43%) indicated that they do not know whether their sexual partners have other partners compared to 41% of the males.

Table 4.22 Gender differences in partner trust (%)

Gender	Do you think your partner has other sexual partners			Total (%)
	No	Yes	Don't know	
Male	26	33	41	100
Female	35	22	43	100

4.5.3.5 Capacity to Adopt HIV Risk Prevention Measures

This section examines indicators that throw light on other features of sexual communication that may have a bearing on the capacity to adopt HIV risk prevention measures. The first indicator concerns the ability to say "no" to sex or refusal of sex without a condom.

Table 4.23 shows that almost 60% of learners engage in safe sex, in that they always refuse sex without a condom. However, a significant percentage of learners engage in risky unprotected sex as 20% indicated that they never refuse sex without a condom, and the other 20% sometimes refuse sex without a condom. The study shows that even though these learners are knowledgeable and concerned about contracting HIV and AIDS from their partners, this did not prevent them from engaging in unprotected sexual intercourse.

Table 4.23 Do you ever refuse sex without a condom (%)

Institution	Response	Male	Female	Total (%)
Brigades	Never	23	16	20
	Always	54	65	58
	Sometimes	23	19	22
Private vocational institutions	Never	29	13	20
	Always	58	67	63
	Sometimes	13	20	17
Technical Colleges	Never	22	19	21
	Always	55	63	58
	Sometimes	23	18	21
Overall Total	Never	24	16	20
	Always	55	65	60
	Sometimes	21	19	20

There is surprisingly not much difference between males and females with respect to the ability to say no to sex without a condom (Table 4.24). The finding goes against the generally accepted belief that men are sexually assertive and that women find it more difficult to sexually assert themselves.

Table 4.24 Gender and capacity to adopt risk minimising strategies (%)

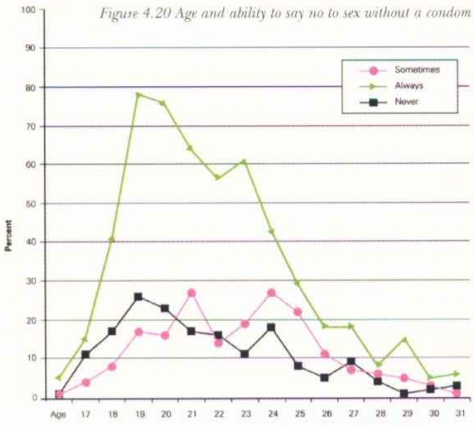
Gender	Do you ever refuse sex without condom			Total (%)
	Never	Always	Sometimes	
Male	23	55	22	100
Female	16	65	19	100

Refusing sex without a condom also has its disadvantages. In focused group discussions, in urban areas such as Gaborone, learners indicated that Sugar Mummies and Daddies make all the decisions about condom use, and as sponsored tom boys and girls they have no say, for fear of losing the financial support.

This slightly higher prevalence of younger learners reporting having failed to say no to sex without a condom for various reasons requires further investigation. In focus group discussions that comprised both male and female, learners recognized pressure from males on females to have unprotected sex as a problem that leads to a rise in HIV infections within the country. There is need for awareness programmes on the danger of unprotected sex, particularly targeted towards male learners who are in the majority of those who never refuse sex without a condom. There is need for intervention at the level of promoting sexual self assertion

Figure 4.20 shows that in terms of age learners who never and/or sometimes refuse sex without a condom are mostly those aged 20 to 22 years, and 22-27 years respectively.

Figure 4.20 Age and ability to say no to sex without a condom



4.6 Factors Affecting Sexual Negotiation and Decision Making

This section discusses the concepts of sexual negotiation and decision making. These issues are important in relation to HIV and AIDS prevention especially in contexts where there are significant power differentials between partners and the less powerful partner is liable to be manipulated or coerced. There has been much written about the gender dynamics of such coercion, with women having been shown in many societies not to be in a position to assert themselves in sex contexts, or to make choices about sexual participation. In the following table the study looks at the extent to which the risk of AIDS has been discussed with sexual partners.

In this study, learners responded to questions of decision making in relationships along gender lines. Females in most cases agree that both partners will make a decision about when to have sex, the type of sex and condom use. On the other hand males in most cases believe it is them who make such decisions.

On issues relating to taking precautions, almost all learners (99%), male and female agree with the statement that safe sex is the equal responsibility of both partners, and did not agree with the statement that said "I do not wear a condom, it is my partner's responsibility (Table 4.25). There is slight difference in agreement with the statement that "my partner and I discuss and agree on who should wear a condom." More females (89%) indicated that they discuss with partners condom use compared to 81% for males.

Table 4.25 Gender disparities in decision making and negotiations (%)

Safe sex is equal responsibility of both partners (%)				Total
		No	Yes	
Gender	Male	1	99	100
	Female	1	99	100
Total		1	99	100
My partner and I discuss and agree on who should wear a condom				
Gender	Male	18.7	81.3	100
	Female	11	89	100
Total		15.5	84.5	100
I do not wear a condom, its responsibility of partner				
Gender	Male	87	13	100
	Female	91	1	100
Total		89	11	100

What falls into conventional thinking is that 13% of males agree with the statement that condom use is the responsibility of the partner. However, this is a small percentage which indicates that increasingly men are taking responsibility in reducing the risk of infection.

Table 4.26 Gender disparities in decision making and negotiations by institution (%)

Institution	Response	Male	Female
Sex is equal responsibility of both partners			
Brigades	No	1	3
	Yes	99	97
Private Vocational Institutions	No	1	0
	Yes	99	100
Technical Colleges	No	1	0
	Yes	99	99
I don't wear a condom, it's the responsibility of my partner			
Brigades	No	84	92
	Yes	16	8
Private Vocational Institutions	No	89	90
	Yes	11	10
Technical Colleges	No	91	92
	Yes	9	8
My partner and I discuss and agree on who should wear a condom			
Brigades	No	18	2
	Yes	82	26
Private Vocational Institutions	No	18	13
	Yes	82	87
Technical Colleges	No	19	12
	Yes	81	88

According to Table 4.26 attitudes appear to be similar across institutions types in regard to decision in relationship.

4.7 Some Additional Insights from Focus Group Discussion

The questions in the focus groups asked students to give their views on the nature and quality of school programs to promote sexual health and to prevent STD and HIV and AIDS as well get views of students on decision-making about sex and sexuality. Focus group discussions are vital as they act as a useful check on the correctness and consistence of data provided by students through questionnaires. The participants in the focus groups were selected in the following manner. Three groups per institution were selected viz. female only, male only and mixed group of both male and female students. A common set of questions was developed by the research team. As well, a common framework for the process used in the focus groups was developed by these researchers. The focus groups comprised at most 15 students. In all 46 focus group discussions were held, 15 of which were male only groups, 16 female only groups and 15 mixed male and female group. Thus, in total at least 690 learners participated in the discussions.

The amount of congruence in the findings of these 46 focus groups suggests that the issues identified here are of considerable importance in our analysis of programs and practices of learners in vocational institutions and public health systems relative to HIV and AIDS and decision-making about sexuality.

4.7.1 Sex and Abstinence

During focus group discussions, learners were asked what sex was. All of them defined sex as vaginal intercourse. It is important to understand whether or not there is a trend towards abstinence but unfortunately such a trend is more difficult to assess than is sexual activity. The findings in this study suggest that at least some respondents have delayed onset of sexual experience through an active decision not to have sex. When learners were asked what abstinence means everyone agreed that the implicit meaning of the term is abstaining from vaginal penetrative intercourse.

4.7.2 Definition of Lovemaking

Females had elaborate ideas about what lovemaking was compared to males. Females consider lovemaking as: sexual intercourse between lovers; just sex; kissing, fondling without penetration, and sharing ideas. Males believe that among the youth it is strictly lovemaking, while cuddling and sharing ideas are for old couples.

4.7.3 Other Forms of Sexual Satisfaction

The focus group discussions were also used to explore issues relating to safe sex i.e. sexual activities that do not put people at risk of infection. Learners also indicated that they practiced other forms of sexual satisfaction other than penetrative sex: oral sex was practiced by over 50% of learners, across gender and institutions; and masturbation by over 40% of male learners, and except for private vocational institutions female learners, by under 40% of females in Brigades and Technical Colleges.

The majority of females do not regard sex as a guaranteed way to make a good relationship even better 90%. They agreed totally with the statement that: sharing thoughts, beliefs, feelings and most of all, mutual respect is what makes a relationship strong. This does not apply to males, whom almost all (99%) believe there is no relationship that can exist without sex. All males believe that sharing thoughts, beliefs, feelings and most of all, mutual respect should ultimately lead to sex.

4.7.4 Life Skills

Learners believe that they need workshops or lessons on life skills, as they believe they could help change learners' attitudes and behaviour towards a number of issues, including HIV and AIDS. Learners believe that all schools from primary onwards must have specialised HIV and AIDS coordinators or teachers. There should be provision of TVs in the institutions so that learners can view the BTV programme "Talk Back".

4.7.5 Role of Media

Learners in all focus groups reported that they learn about HIV and AIDS from the media. Learners' groups also noted that the media can put pressure on youth to be sexually active. They want the government to discuss and study the media's role and influence on sexual behaviour and spread of HIV.

4.7.6 Sexual Orientation

Learners often noted that sexual orientation and discussions of homosexuality are considered to be taboo by their teachers and parents. However, this does not stop learners from being homosexuals.

4.7.7 Challenges Faced by Teachers

Teachers often appeared to be uncomfortable in the eyes of their learners in discussing and teaching certain topics related to sexuality and HIV and AIDS. In their view, the ideal teacher would use humour and other techniques to help learners relax and participate in discussions. Learners in all focus groups also suggested that teachers use more active learning/teaching methods such as role playing, small group discussions and more presentations from guest speakers.

4.7.8 Learners' Suggestions

Student suggested the following issues which they believe could help curb the spread of HIV:

Public figures should declare their HIV status

Improve the HIV and AIDS campaigns and have clearly defined target groups

Abstinence must be encouraged rather than present it as a choice in the ABC slogan

Condom use must be encouraged especially female condoms

Condoms should be made accessible in all training institutions

Parents and teachers should open-up about HIV and AIDS

Commercial sex should be prohibited

ARV provision seems to encourage risky behaviour

Training institutions should have trained HIV and AIDS counsellors

Poverty encourages the spread of HIV so government should create employment

Alcohol abuse in training institutions should be stopped

Pre-testing counselling for HIV is not adequate; it should be improved to make testing attractive to youth not scary as it is the case right now

Lack of entertainment in training institutions encourage indulgence in sex

Health personnel should visit training institutions regularly

Increase distribution of female condom

Lessons on HIV and AIDS should be part of the syllabus

5. Condom Acquisition and Access to Services

Condoms are not a complete solution to the spread of HIV, but they are a necessary tool to combat the spread. In the absence of equally effective alternatives or of evidence that abstinence-until-marriage programs work, there is no scientific basis for restricting access to and information about the only device available to prevent HIV transmission through sex.

While abstinence and fidelity may work for some people in some cases, promoting these behaviours at the expense of condoms deprives people of complete information and services for HIV prevention. To avert the spread of HIV, accessibility to condoms should be improved and there should be a guaranteed comprehensive distribution of condoms among sexually active persons.

From Table 5.1 over 98% of learners in all training institutions surveyed know of a place where one can get a condom. In a follow up question they indicated that they get condoms from hospitals, government clinics, mobile clinics, private hospitals, pharmacy, private doctors, shops, at school, and the workplace. Over 96% of learners indicated that if they wanted they could for themselves get condoms.

5.1 Access to Condoms

In this study, learners expressed their concerns with the unavailability of condoms in their institutions. From focus group discussion males indicated that in the event one is lucky and gets the opportunity for sex it is difficult to resist, and they end up engaging in unprotected sex. In institutions where condoms are distributed, learners complained that there are not placed in convenient places. In other instances, condoms are not distributed frequently.

Table 5.1: Do you know of a place where one can get condoms (%)

Institution	Response	Male	Female	Total
Brigades	No	1	1	1
	Yes	99	99	99
Private Vocational Institutions	No	2	2	2
	Yes	98	98	98
Technical Colleges	No	1	1	1
	Yes	99	99	99
Total	Yes	99	99	99
	No	1	1	1

Those who did not know cited absence of information as the reason, particularly male learners However, the majority of learners, over 80% across gender and institutions, did not experience any problems getting condoms. Only less than 20% across gender and institutions did experience problems. Reasons given are shyness, one's parent is working in the hospital, and condoms placed in inconvenient locations in schools.

Table 5.2: Have you ever had a problem getting condoms (%)

Institution	Response	Male	Female	Total
Brigades	No	84	88	86
	Yes	16	12	14
Private Vocational Institutions	No	81	87	84
	Yes	19	13	16
Technical Colleges	No	83	92	86
	Yes	17	8	14
Total	No	83	89	86
	Yes	17	11	14

The 'chemist or shop' were the most frequently named sources of condoms (80%), and family planning clinics are almost twice as likely to be used by females as a source of condom distribution. An interesting finding and which also says something about the social aspects of HIV risk prevention and HIV discourse, concerns the degree to which respondents acquire condoms from friends. Learners indicated that if they needed condoms they could obtain them socially. Problems associated with condom distribution in clinics, as identified by focus groups are as follows:

Condoms were available only during school or clinic hours

Condoms were available in places which were not easily accessible

Condoms were personally given to people who asked for them. This required an interpersonal encounter which was embarrassing for some learners

Condom boxes were not being replenished and not placed in safe places

Access to the condom distribution point means being seen by others who would know that the person was collecting condoms

Negative attitude on the part of some clinic staff who question behaviour of young people who ask for condoms

Expired condoms were distributed at some centres

Condoms were distributed on request but not proactively promoted

Availability of condoms was not advertised on outside walls of institutions.

5.1 Access to Services

With a number of AIDS campaigns nationwide, most learners are now engaging in safe sexual behaviour. "Preaching" on practising responsible sexual behaviour does not fall on deaf ears. This is shown in the table below. Just a small percentage are still engaging in risky behaviour and therefore contract sexual diseases in the process.

Table 5.3: During the last 12 months, have you ever had a sexually transmitted disease (%)

Institution	Response	Male	Female	Total
Brigades	No	92	92	92
	Yes	8	8	8
Private Vocational Institutions	No	95	95	95
	Yes	5	5	5
Technical Colleges	No	94	90	93
	Yes	6	10	7
Total	No	93	93	93
	Yes	7	7	7

Majority of learners, about 93%, in all the institutions said they never had any sexually transmitted disease (STD) in the past year, that is, during the last 12 months. This is indicated by Table 5.3 above. About 7% of the learners in all the institutions said they have had sexually transmitted disease. In both the Brigades and private vocational institutions, the figures for those who never had STDs for both males and females are constant. In the Technical Colleges these numbers differ slightly, with about 6% of males who had STDs as compared to their female counterparts who are about 10%.

Table 5.4 below depicts that most learners would rather seek advice from health workers in a clinic or hospital in case of an infection from a sexually transmitted disease than seeking help elsewhere. Health services are available in most places nationwide and the service is less costly. But because of some traditional beliefs, some people have indicated that if they were to have sexually transmitted diseases, they would seek advice from traditional doctors.

Table 5.4 If you have a sexually transmitted infection what would you do (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Seek advice from health worker	80	88	78	81
Seek advice from traditional healer	10	5	10	9
Seek advice in a shop or pharmacy	6	4	6	5
Seek advice from friends or relatives	5	2	6	5
	100	**100**	**100**	**100**

In case of a sexually transmitted disease infection, about 81% of learners have indicated that they will seek advice from health workers, 9% will prefer advice from traditional healers. Those who would seek advice or buy medicines in a shop or pharmacy and turn to their friends or relatives for advice account for 5% each.

5.1.1 Counselling Services

Counselling on HIV and AIDS issues is vital, as it helps troubled and ill learners talk about their problems and get better advice about their conditions, and how they can live positively with the disease and those around them. Learners' responses on counselling services in their schools call for a review of the current strategy of engaging instructors, who are not necessarily trained for the job.

Table 5.5 Do you have HIV and AIDS counselling services in your school (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
No	32	48	33	36
Yes	59	11	46	41
Don't know	9	40	21	22
	100	**100**	**100**	**100**

Learners were asked if they were aware of any HIV and AIDS counselling centres in their institutions. About 41% of the learners said they are indeed aware of these counselling centres, 22% indicated that they do not know of the existence of these services, while 41% noted that they do not have HIV and AIDS counselling services in their institutions.

Table 5.6 Are you happy with counselling services in your school (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
No	25	29	42	33
Yes	75	69	58	66
Don't know	0	2	0	0
	100	**100**	**100**	**100**

For those learners who indicated that they were aware of existence of HIV and AIDS counselling services in their institutions, some are happy while others are unhappy with the services being provided. About 33% are not happy, while the remaining 66% have no problem with the provision of these services. Only 2% of those in the Private vocational institutions do not know if they are happy or not.

Table 5.7 Reasons why learners are not happy with counselling service in schools (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
They don't have time to help	43	11	31	33
No confidentiality	8	0	2	4
No workshops	0	0	15	9
Not taken seriously	22	22	17	19
Below standard	11	0	12	10
Not open, counsellors are shy	3	0	5	4
Doesn't exist	5	67	14	15
Sources of info are limited	8	0	5	6
	100	**100**	**100**	**100**

The reasons given by those who are not happy with the counselling services in their institutions are as follows:

Those who are responsible for the provision of these services do not have time or the patience to help learners who are in need of counselling

Counsellors do not keep confidential those things which learners confide in them

There are no workshops whereby learners can freely interact to discuss issues

Counselling is not taken seriously and is at times below the required standards for learners in these institutions

Learners have also indicated that counsellors in their institutions do not openly discuss certain issues with them

Sources of information on HIV and AIDS issues are limited and in some cases non existent

This information is summarised in table 5.7

In private vocational institutions, even from focus group discussions, it came out that counselling services are non-existent; hence 67% of learners in these institutions indicated that the service doesn't exist.

5.2 Testing for HIV

Knowing one's HIV status (negative or positive), is the best way learners can deal with issues of HIV and AIDS more responsibly.

Table 5.8 Reasons given by learners to get an HIV test (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Marriage	19	20	19	19
Family planning	17	17	17	17
Plan for the future	16	17	16	16
Protect partner	15	15	15	15
Protect child	14	14	14	14
If I am sick	9	8	10	9
Know my status	9	8	9	9
	100	**100**	**100**	**100**

Reasons given by learners to get an HIV test: about 19% noted that they would test for HIV because of marriage; 16% so as to plan for the future; 17% for planning reasons; while 15% would to protect their partner; and 14% for purposes of protecting an unborn child. Those who would go to test for HIV just to know their status are about 9%, and so are those who would go if they are sick. All these figures suggest that most learners will consider testing only if there are close to getting married, or when they start

seriously thinking about planning for their future or to protect an unborn child, otherwise they would not voluntarily test for HIV. This calls for BOTA to encourage vocational institutions to encourage learners to voluntarily go for HIV testing, as the absence of such encouragement may worsen the HIV infection among learners.

Although there is a nationwide campaign on HIV testing, some people would still not go for an HIV test.

Table 5.9 Reasons given by learners not to go for an HIV test (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Lose partner	18	13	22	19
Fear of Knowing	58	72	64	64
Stigma	24	14	14	17
	100	**100**	**100**	**100**

19% would not go in fear of losing their partners if they were to test positive. 64% said they are afraid to know their status, while those who are afraid of being stigmatised make about 17%.

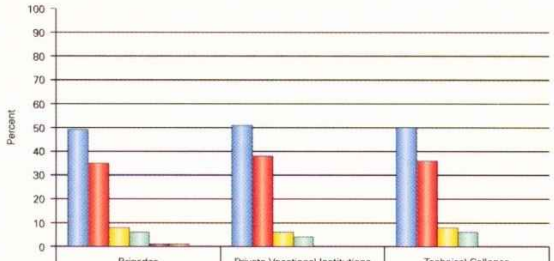
Learners have indicated that they would confide in somebody before having an HIV test. The majority of learners would talk to their parents.

Table 5.10 Who would you talk to before having an HIV test (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Parents	41	44	45	43
Partner	29	30	30	29
Peer educators	13	12	11	12
Friends	8	7	8	8
Teacher	5	5	3	4
Priest	4	3	3	3
	100	**100**	**100**	**100**

From table 5.9 above, 43% of the learners would prefer to talk to their parents, 29% would talk to their partners. Those who would talk to their Peer Educators make about 12% and 8% would confide in their friends. 4% and 3% will talk to their teachers and priests respectively.

Figure 5.1 Who would you tell results of an HIV test



	Brigades	Private Vocational Institutions	Technical Colleges
Parents	49	51	50
Partner	35	38	36
Peer educators	8	8	8
Friends	6	4	6
Nobody	1	0	0
Teacher	1	0	0
Priest	0	0	0

Learners indicated that they will most likely tell their parents and partners because these are people who are too close to them, trustworthy and won't judge them. Only a small portion would tell priests the results of an HIV test.

Table 5.11 below shows some disparities between male and female learners concerning people they could tell their results of an HIV test. Female learners are more comfortable talking to parents (52%) than male learners (48%). The same applies to talking to partners. In relation to peer educators, males are more comfortable telling the results of an HIV test (10%) than females (5%).

Table 5.11 Gender difference in people to tell about HIV results (%)

	Parents	Partner	Peer educators	Friends	Nobody	Teacher	Priest	Public	Sister	Total
Male	48	34	10	7	1	0.3	0.1	0	0	100
Female	52	39	5	3	0.5	0.5	0.2	0.2	0.2	100

5.3 Sex Education

Institutions of learning face challenges when it comes to sex education because teachers have to be careful to use appropriate language. AIDS prevention is difficult because on the one hand teachers want to hold attention, to be relevant and to have impact, while on the other they must not upset or offend. AIDS prevention is most effective as an integral part of sex education or education. However, in educating about sex, teachers always have to be careful that they are not just feeding the imagination and encouraging experimentation. This means that teachers giving sex education should aim imparting information and forming attitudes and beliefs about sex, sexual identity, relationships and intimacy. They should also aim at developing young people's skills so that they make informed choices about their behaviour, and feel confident and competent about acting on these choices.

Table 5.12 Which statement describe the sex education lessons you receive in school (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Lessons about condom use	29	28	31	30
Lessons about healthy lifestyles	17	17	16	17
Lessons on HIV and AIDS	16	17	16	17
Lessons about human sexuality	14	13	13	13
Lessons about risks of unprotected sex	13	13	13	13
Life planning skills	11	11	11	11
	100	**100**	**100**	**100**

Learners were asked to describe the sex education they receive in their institutions. In all the institutions, learners describe sex education they receive mostly as lessons about condom use, supported by 30% of the learners. This is followed by lessons about healthy lifestyles and then lessons on HIV and AIDS which both yield 17% each.

Table 5.13 What does unprotected sex mean to you (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Sex without a condom	90	87	88	88
Sex with more than one partner	10	12	11	11
sex without clothes on	0	1	1	1
sex without contraceptives	0	0	0	0
	100	**100**	**100**	**100**

About 88% of the learners have noted that to them unprotected sex means sex without a condom. Nobody thinks that unprotected sex means sex without contraceptives (other than condoms). Surprisingly, there is 1% to whom unprotected sex means sex without clothes on.

HIV testing should be encouraged at all cost. People should be made aware of the advantages of knowing one's status. Even with HIV and AIDS pandemic most people still do not go for HIV testing. People are still ignorant on HIV and AIDS issues and some do not test for HIV because of fear of stigma and discrimination. Almost half of the learners (49%) have indicated that they have never tested for HIV, and from Table 5.14 below, we see that the majority of those who had never tested are males in Brigades and private vocational institutions.

Table 5.14 Have you ever been tested for HIV (%)

Institution	Response	Male	Female	Total
Brigades	No	56	44	52
	Yes	44	56	48
Private Vocational Institutions	No	65	50	56
	Yes	35	50	44
Technical Colleges	No	45	34	41
	Yes	55	66	59

Some of those who never tested are of the view that testing centres were far from where they are residing. Most of the learners who have gone for an HIV test received counselling before getting tested (Table 5.15).

Table 5.15 Did you receive counselling before getting tested (%)

92% of the learners got a pre-test counselling while 8% did not receive counselling before testing. From Table B5.16, in appendix B, 96% of those who tested got their results and the remaining 4% did not get them. Learners cited the following reasons, as why they did not go for the HIV test results: fear of knowing their status, and not ready. Of those learners who got their HIV results, 85% received counselling after getting their results. The remaining 15% did not receive counselling (Table B5.17).

	Brigades	Private vocational institutions	Technical Colleges	Total
No	6	9	9	8
Yes	94	91	91	92
	100	**100**	**100**	**100**

Table 5.16 If your relative is sick with AIDS would you be willing to care for him/her in your house (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
No	2	4	4	3
Yes	91	86	92	90
Don't know	7	10	4	7
	100	**100**	**100**	**100**

5.4 Stigma

The study of attitudes includes the deliberately general question: What is your attitude to people with AIDS? Despite lessons on HIV and AIDS issues, stigma still exists. People still cannot go out in the open with their HIV status because they are afraid of what other people will say or do.

Most (90%) the learners mentioned that they would be willing to care for a relative in their home if he/she becomes sick with AIDS. 3% said they will not be willing to care for their relative while 7% do not know if they could care for a relative who is sick from AIDS. A few of those who responded to a follow up question to establish why they will not be willing to care for their AIDS sick relatives, are of the view that it's the sick person's problem, and also that they did not want to get infected.

Table 5.17 Should an HIV positive teacher, who is not sick, be allowed to continue teaching in your school (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
No	4	2	3	3
Yes	93	95	95	94
Don't know	3	2	2	2
	100	**100**	**100**	**100**

A few learners, about 3%, who believe such a teacher should not continue teaching because of the risk of infecting other people, and being unproductive as they will be on sick leave most of the time. 2% do not know if they would allow a sick teacher to continue teaching while 94% definitely think that an HIV positive teacher should be allowed to continue teaching.

Table 5.18 Would you share the following with an HIV positive learner (%)

Institution Type	Room	Sports Facilities	Bath Tub	Dining Table	Toilet	Utensils	Bed
Brigades	67	57	40	39	39	34	30
Private Vocational Insitutions	60	52	37	37	36	32	30
Technical Colleges	76	61	43	43	42	38	33

Learners were allowed to pick more than one option in responding to the above question. Each percentage was obtained by dividing the number of learners who picked an option by the total population of learners surveyed per institution. The results show that a large proportion of the learners in all types of institutions are most likely to prefer sharing rooms with HIV positive learners but least likely to share a bed with an HIV positive learner. This could be due to learners' perception that sharing a bed is like engaging in sexual intercourse hence the least likelihood of wanting to share a bed with an HIV positive learner. Among all the institutions a lesser percentage of the learners say they would share a bed with an infected learner. These percentages are slightly smaller than those who would want to share utensils with affected learners. This may possibly mean learners associate sharing utensils such as plates, spoons and forks with the transmission of the HIV virus. 61% of the learners in Technical Colleges say they would share sporting facilities with HIV positive students as compared to 52% in private vocational institutions and 45% in Brigades. This suggests that negative perceptions still exists among minority of learners towards those suffering from HIV and AIDS.

5.5 Awareness, Assessment, and Impact of School HIV and AIDS Education among Learners

The data indicate that peer education, counselling and drama lessons on issues of HIV and AIDS in Technical Colleges, though irregular, and underdeveloped are successfully reaching and changing the behaviour of a significant proportion of learners. Learners who attended any of these sessions generally have a very positive assessment to them and their impact on them. Moreover, many learners, including those who are sexually experienced, report that they have taken positive action in response to these lessons that could decrease their risk of HIV infection. In addition, learners who attended these lessons indicate that they value communication and that they have given them the opportunity to talk to their parents about sensitive issues such as sex and relationships.

5.5.1 Reported Awareness

Level of awareness is very important when dealing with HIV and AIDS issues. Having awareness on issues of sexuality, sex and HIV and AIDS usually reduces risk of getting into risky behaviour. In all the institutions most of the learners agree that peer educators have played a role in teaching them about sex, sexuality and HIV and AIDS. From table 5.19 below, 38% strongly agree with the statement, those who agree account for about 49% and those who do not agree give only 13%.

Table 5.19 Peer educators taught me about sex, sexuality and HIV and AIDS (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Strongly agree	39	38	36	38
Agree	50	48	50	49
Do not agree	11	13	15	13
	100	**100**	**100**	**100**

Most learners, accounting for 44%, strongly agree that drama competition taught them about sex sexuality and HIV and AIDS while only 14% do not agree. 30% do not agree that learners' counsellors taught them about sex, sexuality and HIV and AIDS. They pointed out that the student counsellors are shy to discuss these issues with them (see Tables B5.18 and B5.19).

Table 5.20 Which statements clearly describes the sex education lesson from peer educators (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
Basic facts on HIV and AIDS	47	48	48	48
New healthy lifestyle for young people	21	21	21	21
Condom advertisement/promotion	16	15	16	16
Risks of unprotected sex	16	16	15	16
	100	**100**	**100**	**100**

The majority of learners have noted that basic facts on HIV and AIDS clearly describe the sex education lessons from peer educators, indicated by 48%. About 39% of the learners stated that positive living with HIV and AIDS if infected best describes sex educations lesson from school counsellors.

5.5.2 Reported Assessment

From Table B5.22 in appendix B, for 92% of learners, peer education, counselling, and drama lessons on HIV and AIDS are very good for learners as they are important sources of information. And from Table B5.23, 81% of learners did not find their presentation in English as a problem. However, 19% of learners did.

Peer education had the largest effect, as a large majority of learners believe that it made them think about making safer choices; talk about sex in a positive way; felt it reflected well issues of young people's aspirations and lifestyle; and got learners interested in issues of HIV and AIDS (see Table B5.24 in appendix B). However, 11% of the total sample felt that the lessons were boring and were not interesting, while 8% of the total sample regarded them as vulgar and did not like them.

5.5.3 Reported Impact of School HIV and AIDS Education among Learners

Research suggests that people are more likely to hear and personalize messages, and thus to change their attitudes and behaviours, if they believe the messenger is similar to them and faces the same concerns and pressures. According to Mason (2003) numerous studies have demonstrated that their peers influence learner's health behaviours, not only in regard to sexuality but also in regard to violence and substance use. Peer education draws on the credibility that learners have with their peers, leverages the power of role modelling, and provides flexibility in meeting the diverse needs of today's learners. Peer education can support young people in developing positive group norms and in making healthy decisions about sex. For this study, the issue of peer education was assessed in relation to sex education.

Based on the lessons, generally, the majority of learners agreed that if they took positive action that could decrease their risk of HIV infection. The actions taken involve: increased awareness of the risks of unprotected sex; talking to their friends and relatives about HIV and AIDS; thinking more about the openness and honesty of their romantic relationship; looked for more information on HIV and AIDS, sex, sexuality and relationships between men and women; attending to a clinic or private doctor to test for HIV; reducing the number of sexual partners they had; and using condoms when having sex.

The majority of learners described the impact the peer education, counselling and drama lessons had on them as follows: made them to be more aware of risks of unprotected sex; caused them to talk to friends about HIV and AIDS; caused them to think more about the openness and honesty of their romantic relationship; caused them to make behavioural changes, including delaying or abstaining from sex; caused them to talk more openly with their partners about HIV and AIDS, sex, and who should prevent getting infected; and to some extent, caused them to explore other forms of sex activity, like masturbation and oral sex (Table 5.21).

Table 5.21 Which statement best describes the impact the peer education, counselling and drama lessons had on you (%)Caused me to be more aware of the risks of unprotected sex

Caused me to be more aware of the risks of unprotected sex		**No**	**Yes**	**Total**
Brigades		2	98	100
Private Vocational Insitutions		2	98	100
Technical Colleges		3	97	100
Total		2	98	100
Caused me to talk to my friends about HIV and AIDS				
Brigades		7	93	100
Private Vocational Insitutions		5	95	100
Technical Colleges		8	92	100
Total		7	93	100
Caused me to think more about the openness and honesty of my romantic relationship				
Brigades		17	83	100
Private Vocational Insitutions		11	89	100
Technical Colleges		10	90	100
Total		13	87	100
Caused me to make behavioural changes, including delaying or abstaining from sex				
Brigades		16	84	100
Private Vocational Insitutions		12	88	100
Technical Colleges		10	90	100
Total		13	87	100
Caused me to talk more openly with my partner about HIV and AIDS, sex, and who should prevent				
Brigades		9	91	100
Private Vocational Insitutions		7	93	100
Technical Colleges		5	95	100
Total		7	93	100
Caused me to explore other forms of sex activity, like masturbation and oral sex				
Brigades		41	59	100
Private Vocational Insitutions		53	47	100
Technical Colleges		43	57	100
Total		45	55	100

As a result of peer education, counselling and drama lessons many students have: used condoms when having sex; limited the number of sex partners; been more assertive in insisting on condom use; abstained from having sex; reduced sex partners; and did not have sex more often (Table 5.22).

Table 5.22 As a result of peer education, counselling and drama lessons I have ...(%)

Used condom when having sex		**No**	**Yes**	**Total**
Brigades		2	98	100
Private Vocational Insitutions		3	97	100
Technical Colleges		4	96	100
Total		3	97	100
Limited number of sex partners				
Brigades		7	93	100
Private Vocational Insitutions		5	95	100
Technical Colleges		9	91	100
Total		8	92	100
Been more assertive in insisting condom use				
Brigades		18	82	100
Private Vocational Insitutions		4	96	100
Technical Colleges		11	89	100
Total		11	89	100
Had sex more often				
Brigades		74	26	100
Private Vocational Insitutions		70	30	100
Technical Colleges		64	36	100
Total		69	31	100
Abstained from having sex				
Brigades		34	66	100
Private Vocational Insitutions		32	68	100
Technical Colleges		30	70	100
Total		32	68	100
Reduced sex partners				
Brigades		9	91	100
Private Vocational Insitutions		6	94	100
Technical Colleges		12	88	100
Total		9	91	100

Learners have indicated that the lessons on peer education, counselling and drama have a good impact on them. Because of the good role these lessons are playing, learners have become more aware of the risks of unprotected sex. Learners can now talk to their friends about HIV and AIDS, sex, sexuality and relationships between men and women. In addition, learners have learnt how to make behavioural changes, including delaying or abstaining from sex. Peer education, counselling and drama lessons had an impact on learners by helping them to talk more openly with their partners about issues of HIV and AIDS, sex and who should be responsible regarding prevention. To a lesser extent, these lessons have caused learners to explore other forms of sexual activity, such as masturbation and oral sex.

Table 5.23 Did lessons help you understand better issues of HIV and AIDS (%)

	Brigades	Private vocational institutions	Technical Colleges	Total
No	3	2	4	3
Yes	97	98	96	97
	100	**100**	**100**	**100**

In a follow up question, however, few learners are of the view that lessons would have help them understand issues of HIV and AIDS better if they were taught in Setswana for better clarity. Other learners indicated that additional and accessible information on HIV and AIDS could help augment peer education, drama competitions and counselling lessons, and that televisions must be used to disseminate such information.

Learners have indicated that lessons on peer education, counselling and drama have played a significant role in making them to freely talk to their parents or spouse concerning issues such as HIV and AIDS, relationships between men and women, issues on sex as well as other difficult issues which need to be discussed.

Table 5.24 Did peer education, counselling and drama lessons help you to talk to others (%)

	Friends	Mother	Brother or Sister	Father	Others	Total
No	3	22	12	31	8	14
Yes	97	78	88	69	92	86
Total	100	100	100	100	100	100

Table 5.24 above shows that as a result of lessons on peer education, counselling and drama lessons, the majority of learners can now freely talk to those around them. The majority of the learners would prefer to talk to their friends, siblings and other people that they mostly interact with, like cousins and peers. With these lessons, fewer learners still do not feel more able to talk to their fathers.

From the information depicted by Table B5.26 in appendix B, open communication about sex and sexuality can help reduce the risk of HIV and AIDS, help reduce the risk of teen pregnancy, encourage adolescents to be more responsible and encourage adolescents to delay sex. Only a small percentage of the learners do not agree with these and believe that open communication about sex and sexuality have no value.

6. Conclusions

Lessons that emerge clearly from the study are that learners have the correct knowledge about HIV prevention and how it is transmitted. More than 90% know all the correct ways to avoid HIV infection. However, only 14 % have abstained from sex and almost 80% of those who are sexually active are consistently using condoms.

Chris Batsalelwang, BOTA HIV & AIDS Coordinator

The figures show a significant percentage that is not practicing the two most effective ways of preventing infection and unwanted pregnancy which are abstinence and consistent condom use. This is further compounded by the prevalence of commercial sex, where it was reported that sex in exchange for money or gifts with older partners is not uncommon among learners, particularly female learners. Young females who date older partners are not in a position to negotiate for safe sex.

Condom use is high especially among both males and females who are sexually active. More positively, the majority of learners, about 89%, indicated that the last time they had sex before the survey, they used condoms. The majority of learners, 86%, across all vocational training institutions, indicated that they could get condoms easily if they wanted them. However a significant number indicated that they couldn't, because their close relatives are working in places where they could get condoms. For most sexually active learners, hospitals, family planning clinics and government health centres are the main top three places to get condoms. However, about 33% of learners rated the treatment they get from health facilities as average, 30% rated it very good, 25% good, and 13% rated the treatment poor.

Despite knowledge of the risks of HIV infection, a significant percentage of sexually active learners engage in risky unprotected sex as 20% indicated that they never refuse sex without a condom, and the other 20% sometimes refuse sex without a condom. The practice of simultaneous multiple sex partners and inconsistent condom use among some learners in the vocational training sector is troubling. Although the majority practice safe sex, there is need for awareness programmes on the danger of unprotected sex, particularly targeted towards male learners who are in the majority of those who never refuse sex without a condom. Even more troubling is the fact that half of learners have not tested for HIV, which by itself, exposes them to the risk of infection.

Furthermore, learners in this study have good access to accurate HIV and AIDS information and that they are regularly being exposed to HIV and AIDS media from a range of different sources. It is further encouraging despite apparent weakness to note that training institutions are playing an active role to educate learners on issues of HIV and AIDS. Half of learners reported their source of information on HIV and AIDS as teachers. Learners' major sources of HIV and AIDS information are TV, magazines and parents. More encouraging is the finding that parents have started to participate more actively as a source of information on HIV and AIDS to learners. It is further encouraging noting that in a majority of cases the decision to have sex is undertaken wilfully by both partners. However in a significant percentage of cases male learners still dominate female learners in decisions relating to sex.

Participants at BOTA HIV and AIDS Stakeholders Workshop, March 2006

7. Recommendations

The study suggests that learners in the vocational training sector are not a homogenous group although all of them are pursuing similar training.

Some are more sexually experienced than others, while some are highly sexually active and others have multiple partners. The following recommendations are essential for developing social marketing strategies that might be useful among the youth.

Intervention programmes to empower females cannot work unless there is also work to change the behaviour of the other half viz. males. There is need to motivate both males and females to talk openly about sex, and HIV and AIDS, and encouraging males to take care of themselves, their partners and their families. Strategies aimed at encouraging behavioural change of men in the fight against AIDS should be emphasised.

HIV and AIDS focal persons should be trained to acquire skills on how to impart issues of HIV and AIDS to learners effectively. They should also be able to encourage parents to discuss issues of HIV and AIDS and sexual health needs of learners. Furthermore, there should be strategies for instilling behavioural change in VT learners and enhancing sexual, health and HIV and AIDS knowledge.

Sex educators and HIV and AIDS coordinators should be equipped with skills that would enable the learners to develop skills and abilities to be sexually responsible.

BOTA should encourage the training institutions to set up user-friendly, safe and easily accessible condom distribution points within the institutions by installing condom dispensers at strategic places such as toilets and hostels.

There is need for education programme frameworks that address positive-learner development as a longer term goal. Learners must continue to be involved and encouraged to openly present their views in educational programme design in order to assure programme relevance, ownership and participation.

Training institutions should create linkages between skills development and income generating programmes such as micro- enterprises, livelihood projects to promote gender equity at the individual and societal levels to empower female learners and subsequently reduce their desire to engage in commercial sex and other risky behaviours.

Mass media and informal communications, peer education and drama competitions can help break taboos on sensitive topics and promote the discuss-ability of sex and HIV and AIDS, assist in the process of changing social norms, reach large numbers at a modest cost and disseminate practical information. Researchers need to explore the risk factors for males and females in the use of condoms to help determine the type of interventions suitable for each category.

Education campaigns on issues of HIV and AIDS should take account of age differences and situations and address them accordingly. Formal and informal sex/HIV education programs should identify learners' popular venues for reaching learners with needed information.

There is need to adopt community-based strategies that involve community leaders in campaigns to change the traditional practices, beliefs and stereotypes that increase vulnerability of females and males to HIV. This will encourage both males and females to take joint responsibility for protecting one another from infection.

Modules/sessions on HIV and AIDS in vocational institutions should include several strategies like the use of condoms, sticking to one partner, promiscuity, avoiding many partners, and abstinence. These should also encourage positive decision making, respect and understanding of partners decisions relating to lovemaking.

Information on voluntary counselling and testing should be made available in all vocational institutions to encourage learners to voluntarily test for HIV and AIDS.

BOTA HIV and AIDS Field Officer

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Appendix A

Reference Group KAB Study

Ezekiel Thekiso - **BOTA** - *Chairperson of the Reference Group*

Ulla Tschoetschel - **BOTA** - *Secretary of the Reference Group*

Mothebe Madanika - **BOTA** - *HIV and AIDS Field Officer*

Masego Gwaila - **BOTA** - *Policy and Planning Coordinator*

Ben Gareegope - **NACA** - *IEC Officer*

Mosetsana Maribe - **DVET** - *HIV and AIDS Coordinator*

Chris Modikwa - **BAPVOS** - *Treasure*

Irene Main - **UNAIDS** - *Programme Associate*

Mona Drage - **UNAIDS** - *Programme Officer*

David Ngele - **BONEPWA** - *Executive Director*

Prisca Tembo - **BOTUSA** - *BCC Coordinator*

Jeffrey Makgolo - **BBCA** - *Coordinator*

Appendix B

Tables

Table B4.0 *Sometimes I have sex even though my girl/boyfriend/partner/wife/husband does not want to (%)*

Institution	Response	Male	Female	Total
Brigades	No	75	83	78
	Yes	25	17	22
Private Vocational Institutions	No	80	88	84
	Yes	20	12	16
Technical Colleges	No	75	81	77
	Yes	25	19	23

Table B4.1 *If my girl/boyfriend/partner/wife/husband says no to sex, I do not insist on having sex with her*

Institution	Response	Male	Female	Total
Brigades	No	16	14	15
	Yes	85	86	85
Private Vocational Institutions	No	25	15	20
	Yes	75	85	80
Technical Colleges	No	19	10	16
	Yes	81	90	84

Table B4.2 *If my girl/boyfriend/partner/wife/husband says no to sex, I accept it (%)*

Institution	Response	Male	Female	Total
Brigades	No	11	5	9
	Yes	89	95	91
Private Vocational Institutions	No	17	5	10
	Yes	83	95	90
Technical Colleges	No	13	7	11
	Yes	87	93	89

Table B5.16 *Did you receive your HIV and AIDS test results (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
No	4	1	5	4
Yes	96	99	95	96
Total	100	100	100	100

Table B5.17 *Did you receive counselling after getting your results (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
No	14	16	15	15
Yes	86	84	85	85
Total	100	100	100	100

Table B5.18 *Student Counsellors taught me about sex, sexuality and HIV and AIDS (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
Strongly agree	29	23	19	23
Agree	45	48	47	46
Do not agree	27	29	35	30
Total	100	100	100	100

Table B5.19 *Drama competitions taught me about sex, sexuality and HIV and AIDS (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
Strongly agree	50	38	42	44
Agree	40	43	42	42
Do not agree	9	18	16	14
Total	100	100	100	100

Table B5.20 *Which statements clearly describes the sex education lesson from school counsellors (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
Positive living with HIV and AIDS if infected	38	39	41	39
Information on various providers of HIV services	22	20	21	21
Encouraging HIV testing	21	21	20	20
Discussing HIV and AIDS more freely	20	20	19	19
Total	100	100	100	100

Table B5.21 *Which statements clearly describes the sex education lesson from drama competitions (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
HIV and AIDS issues	36	34	35	35
Importance of testing for HIV and AIDS	23	24	24	24
Basic facts on HIV and AIDS	21	21	21	21
To be faithful to your partner	19	20	20	20
Total	100	100	100	100

Table B5.22 *Do you think the lesson is good for students in your school (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
Bad for students in my school				
Peer education	8	3	6	6
Counselling	1	1	2	1
Drama	1	1	1	1
Total	11	5	9	8
Good for students in my school				
Peer education	35	41	42	39
Counselling	28	30	27	28
Drama	26	24	23	24
Total	89	95	91	92
	100	100	100	100

Table B5.23 *Is presentation of the lesson in English a problem for you (%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
No	78	89	79	81
Yes	22	11	21	19
Total	100	100	100	100

Table B5.24 *Having attended the lessons which of the following statements do you agree with(%)*

	Brigades	Private vocational institutions	Technical Colleges	Total
It made me think about safer choices				
Peer education	61	61	64	62
Counselling	23	22	20	22
Drama	16	17	16	16
Total	100	100	100	100
It was different and I was interested				
Peer education	59	58	68	62
Counselling	21	23	18	21
Drama	20	19	15	18
Total	100	100	100	100
It reflected young peoples aspirations and lifestyles				
Peer education	68	65	67	67
Counselling	18	20	17	18
Drama	14	15	15	15
Total	100	100	100	100
I talked about sex in a positive way and I liked it				
Peer education	64	58	71	65
Counselling	22	25	16	21
Drama	14	16	13	14
Total	100	100	100	100
It was boring and I was not interested				
Peer education	78	80	74	76
Counselling	13	11	19	16
Drama	9	9	7	8
Total	100	100	100	100
It was vulgar and I did not like it				
Peer education	89	83	72	81
Counselling	8	10	19	13
Drama	3	7	9	6
Total	100	100	100	100

Table B5.25 *Did peer education, counselling and drama lessons help you to talk to your parents/spouse about . . . ? (%)*

	HIV and AIDS	Relationships between men and women	Other difficult issues	Sex	Total
No	11	16	19	17	15
Yes	89	84	81	83	85
Total	100	100	100	100	100

Table B5.26 *Do you think more open communication about sex and sexuality can (%)*

	Help reduce the risk of HIV and AIDS	Help reduce the risk of teen pregnancy	Encourage adolescents to be more responsible	Encourage adolescents to delay sex	Encourage adolescents to initiate sex	Have no value	Total
No	3	4	6	16	45	66	17
Yes	97	96	94	84	55	34	83
	100	100	100	100	100	100	100

Even though, they have knowledge about HIV and about modalities of transmission, many learners in training institutions in Botswana do not perceive themselves as being at risk of infection. In order to decrease transmission rates among learners, quality HIV and AIDS education must be implemented in a culturally relevant manner. There is also a need to motivate both males and females to talk openly about sex, and HIV and AIDS, and encourage males to take care of themselves, their partners and their families. Strategies that engage males as partners in fighting AIDS are the surest way to change the course of the epidemic.

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