

HIV AND AIDS KNOWLEDGE AND ATTITUDES AMONG FORM THREE JUNIOR SECONDARY SCHOOL STUDENTS IN KWENENG AND CENTRAL DISTRICTS

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ABSTRACT

This article explores HIV and AIDS knowledge and attitudes of students in their final year of junior secondary school. Though a lot of studies have been carried out about youth and HIV it seems a few have focused on the attitudes of Junior Secondary school students. This category of students is most problematic because of sex related hormones that are combined with the developmental stage (Austin, 1995; DiClemente, 1996) that make teenagers risk takers as they experiment with everything including their bodies. A closed questionnaire was administered to 602 students from which 450 questionnaires were valid. The findings were analysed using descriptive statistics. The AIDS Risk Reduction Model (ARRM) and the Health Belief Models (HBM) are used to understand the current knowledge and attitude of form three students. The following are some of the findings: some students do not perceive themselves at risk of getting infected with HIV; most students still harbour negative attitudes towards HIV and AIDS as they want the status of a sibling who is HIV positive to be kept as a secret; despite evidence of stigma, a large percentage, 62% don't think that HIV and AIDS is a punishment for an immoral life. These attitudes partially explain why pregnancy is still the leading cause of school-drop outs. The paper concludes that students are knowledgeable on HIV and AIDS issues but still harbour negative attitudes towards people living with HIV and AIDS. Therefore continued education to address stigma is necessary. The study recommends that the skills problem must be addressed in order to reduce the HIV and AIDS incidence rate.

Key words: HIV and AIDS, incidence rate, negotiation and refusal skills, career subject

INTRODUCTION

Botswana is one of the countries that are hardest hit by HIV and AIDS. The epidemic still remains one of the country's challenging health issues (Mogomotsi, 2004). The latest HIV survey revealed an estimated national HIV prevalence at 16.9% and an HIV incidence of 2.47% for the population six weeks and over (BAIS IV, Statistics Botswana, 2013, p.4). The HIV incidence figure is the most worrisome as it 'measures the degree of new infections' (BAIS IV, Statistics Botswana 2013, p.3). This means that more and more people keep on getting infected by HIV and AIDS. Different variables have been adopted in an effort to understand HIV and AIDS. Early studies focused on the geography of HIV and AIDS since the objective was to establish the origin of the diseases and the patterns of spread (Cliff & Smallman-Raymor, 1992). Extant and extent literature arose that focused on the gender variable (Elice 2016), the vulnerability of women (Preece, 2001, Rakgoasi, 2010) especially girls (Coldrey, 1996, Chirwa, Kasonde-Ng'andu, Kalimaposo, 2016) and widows (Butts et. Al., 2018). The age

variable has been minimally explored. After analysing the 2013 BAIS IV results, Ellece (2016) concludes that ‘In Botswana gender inequality has been identified as the main cause of higher infections among women’ (2016, p.276, Preece, 2001, Rakgoasi, 2016).

The first Botswana National Policy on HIV and AIDS was developed in 1993 with subsequent revisions in 1998 and 2012 (The Revised national Policy on HIV and AIDS, 2012, p.1). The latest policy on HIV and AIDS takes cognisance of the fact that ‘due to age, gender, socio-economic status, sexual orientation or disability, some Batswana are more susceptible to the devastating effects of HIV and AIDs than others (Revised Botswana National Policy on HIV and AIDS, 2012, p2). Similarly, the Health Belief Model lists age and gender as one of its modifying factors. With so many studies having been carried out internationally and in Botswana on the impact of HIV and AIDS, despite such known information about the devastating impact of the disease on young people, attention is rarely given to the connection between HIV and AIDS and the contemporary knowledge and attitude among the youth in secondary schools in Botswana. Therefore the aim of this paper is to acknowledge that age is indeed a factor in the fight against HIV and AIDS. In order to contribute to the debate this article explores HIV and AIDS knowledge and attitudes of students in their final year of junior secondary school in Kweneng District. Attitudes are very important because they determine the course of action that one is likely to take. This category of the society is challenged partly because of the developmental stage they are at, precisely in relation to sex-related hormones (Austin, 1995; DiClemente, 1996). Compared to students in senior schools they are statistically hard hit by teenage pregnancy. Generally teenagers are risk takers as they experiment with everything including their bodies. Therefore understanding what attitudes and knowledge they have in the present Botswana might contribute to explaining the incidence of HIV after so many years of information dissemination. The findings might further influence the kind of solutions that are relevant in the fight against HIV and AIDS specific to this age category.

Government and HIV and AIDS Preventative Measures

The government has taken a political will power and commitment to fight HIV and AIDS through policies and programmes. The first policy on HIV and AIDS, the 1993 National Policy on HIV and AIDS identifies different causes for the rapid spread of the disease; the extreme mobility of the population; advanced communication systems; high rate of other STDs aligned to the multiple partners and the frequent change of partners (Botswana Government, 1993). The government then introduced different programmes such as Prevention of Mother to Child Transmission (PMTCT), the roll-out of the ARVs treatment, opened Voluntary Testing and Counselling Centres at strategic places throughout the country. It also engaged different non-governmental organisations such as Peace Corps among others. All these efforts were done in order to address challenges posed by HIV and AIDS. Furthermore, the government through the Ministry of Education and Skills Development (now referred to as the Ministry of Basic Education) came up with programmes that focused on students in schools.

HIV and AIDS intervention Programmes in Botswana: education

Until 2000, the Botswana education sector’s responses to HIV and AIDS were very limited. The epidemic was mainly seen as a health issue and the broader relevance on HIV

AND AIDS to the sector was not widely appreciated or formalised in its policies and structures (Kinghorn, Coombe, & McKay Johnson 2002). However this was not to remain a health issue as the prevalence of HIV and AIDS among women receiving antenatal care was at 37.4% in 2003 (NACA). These children will eventually enter the education system. Ultimately the education sector could no longer disassociate itself from HIV and AIDS issues but act! The Ministry of Basic Education had to come up with specific strategies to address HIV and AIDS; a momentum was created by a presidential requirement for responses in each sector, and accountability and reporting to NACA (Kinghorn, Coombe, & McKay Johnson 2002). HIV and AIDS coordinators were appointed. Technical Working Groups composed of focal point persons from all Departments were established to plan and coordinate the Ministry's response. A Strategic Plan, including sub-plans for all Departments and certain key divisions, institutions and units were formulated in February 2001. The group found the following to be imminent in relation to the epidemic (Kinghorn, Coombe, & McKay Johnson 2002):

- What is the role of Education in preventing the spread of HIV among young people?
- How does the sector ensure that all young people, including orphans and other vulnerable children (OVC), achieve their full development potential?
- How does the sector, the country's largest employer, prevent HIV infections among its employees?
- How does the sector continue to improve access and quality of services in the face of the impact of HIV and AIDS on capacity to deliver services?

To react to this, one of the urgent things to do was to ensure that students were informed on the facts about HIV and AIDS: 'The main approach of the Ministry of Basic Education to HIV and AIDS education has been to infuse topics into other subjects already in the curriculum. Content was biased mainly towards technical aspects of HIV and AIDS,' (Kinghorn, Coombe, McKay & Johnson 2002, p.12). HIV and AIDS education was infused into subjects such as Guidance and Counseling. Information on HIV and AIDS was further delivered through radio programme, the Educational Broadcasting, hence the disease was popularly referred to as the 'radio disease'. The group recommended, (Kinghorn, Coombe, McKay & Johnson 2002, p13) among others, the following:

- Fast track development of a stand-alone HIV and AIDS and life skills programme to provide a more focused and holistic approach to HIV and AIDS than achieved through infusion.
- Strengthen and extend the current infusion-based programmes but recognise their limitations
- Aggressively extend initiatives to all levels of primary schooling to reach children before they become sexually active.
- Strengthen peer education approaches and, in particular, the PACT programme.
- Aggressively increase HIV and AIDS training for staff in co-ordination with workplace prevention and impact management programmes.
- Develop ways to address home, community and cultural issues that are undermining school programmes, (Kinghorn, Coombe, McKay & Johnson 2002, p.13) though a

recommendation was made in 2002 that a standalone programme is provided in the fight against the epidemic such information was still infused in the curriculum.

The infusion of HIV and AIDS education into the already existing curriculum, though with observed limitations, is consistent with findings elsewhere (Stockton, Nitza & Bhusumane, 2010; Sefhedi, Montsho & Mpfu 2008). Several HIV and AIDS-related counseling programmes have been presented in Botswana schools. These included life-skills education, sexual and reproductive health education, voluntary testing and counseling, health and safety education, behavioural change, care and support (Sefhedi, Montsho, & Mpfu, 2008). These are key components of a comprehensive in-school HIV and AIDS prevention curriculum (Barth, 2004; Mpfu *et al.*, in press). However limited evaluations of these have been carried out to see the extent to which education has translated into change in behaviour by students. Their other finding was that the ‘providers of in school HIV and AIDS counseling services perceived significant training needs in respect of themselves (Sefhedi, Montsho, & Mpfu, 2008). Stockton, Nitza & Bhusumane reviewed the development of professional counseling in Botswana and concluded that ‘school guidance and counseling in Botswana...many of those working as counselors have limited training’ (2010, p.10). They also found that such counselors report of themselves as experiencing ‘on-going difficulties and need more training in dealing with the many social problems in schools, number of HIV orphans, secrets and stigma surrounding the disease, (Stockton, Nitza & Bhusumane, 2010, p.11).

Another effort by the Ministry Of Basic Education to fight the scourge was implementing the Teacher Capacity Building Project (TCBP). The goal of the project was ‘to contribute to the prevention and mitigation of the impact of HIV and AIDS by strengthening the capacity of the education and communication sectors to deliver interactive, distance HIV and AIDS education primarily to teachers so that they act as agents of behavior change among the in-school youth. One of the components of the TCBP programme is an HIV and AIDS live teacher education television programme called Talk Back, (Nleya & Segale 2013, p.2). The evaluation of the programme revealed that there are ‘several myths, beliefs, misconceptions, and attitudes about HIV and AIDS that exist among Botswana teachers and students and thus make it difficult for the Talk Back programme to impart the HIV and AIDS message successfully. Therefore, there is a need for more stakeholders in HIV and AIDS education, with appropriate learning techniques used to bring about the desired behavioural change’ (Nleya & Segale 2013, p.2). This project was not only geared towards imparting knowledge but to provide a more effective way to ensure change in behaviour. This was to ensure that education is complemented by imparting life skills to students. This article evaluates the extent to which students display knowledge about HIV and AIDS and their attitudes towards people living with AIDS given the effort that the government has made to empower students.

The government further introduced *The Ministry of Education and Skills Development Strategic Framework for HIV and AIDS 2011-2016*’ policy. It was formulated in order to ‘enable the Ministry to set out its approach and plans to mitigate the impact of HIV and AIDS in the education sector’ (NACA, 2012, p.26). In conclusion, though the government of Botswana has put in place all these programmes, risky behaviours such as unprotected sex

resulting in teenage pregnancies, the use and abuse of drugs in schools are a cause for concern. This indicates that there is a discrepancy between knowledge and behaviour which does not lead to a significant change in attitude. According to the ARRM and HBM for any change in behaviour to take place students must perceive themselves as being a risk. Therefore it is important to understand what knowledge and attitudes currently prevail among junior secondary school students.

Purpose of study

This study is informed by my personal experience as a teacher at secondary schools, a lecturer at teacher training colleges and at the University. I have observed that though students have knowledge about HIV and AIDS they still portray risky behaviours. Such risky behaviours include unplanned pregnancy, and the use and abuse of alcohol and drugs as evidenced by disciplinary problems in schools (Garegae, 2007). The study is further informed by the realities of the impact of HIV and AIDS in Botswana on the general population and in particular the continued report of new HIV infections or incidence rate per each BAIS. The paper is driven by the following two questions: What knowledge about HIV and AIDS do students have and what attitudes about HIV and AIDS do students have?

Current Knowledge status on HIV and AIDS and Young People

Like the general population, teenagers in Botswana are infected and affected by HIV and AIDS. Many factors explain the vulnerability of teenagers to infection. Such factors will range from cultural silence about sex issues (Carretta, Burgess & DeMarco 2015; Yates, 2016; Plummer & Njuguma 2009), the unequal power relations between adult males and teenage girls (Luke, 2005, Dahl, 2015), the experiential and risky nature of the teen-age (Austin, 1995) as well as concealing of cases of rape/defilement and incest at family level (Coldrey 1996; Chirwa, Kasonde-Ng'andu & Kalimaposo, 2016). At their age, form three students might not be emotionally mature to handle HIV and AIDS related challenges. The importance of packaging the HIV and AIDS messages according to specific child developmental stage have been discussed (Austin, 1995; DiClemente, 1996; Alder & Rosengard, 1996). For instance, Austin says that at adolescent stage students 'focus on achieving independence by forming an identity, developing a positive body image, developing an inner conscience defining sex and learning about sex relationships' (1995, p.119). He further explains that at this stage any HIV and AIDS message needs to 'emphasise moderation and interventions more than prevention. Adolescents seek solutions not preaching and they want to be part of the solution rather than viewed only as problems' (Austin, 1995, p.123). If students do not change towards safer behaviours then the education system and the country at large will continue having new infections. Overtime this will not be economically viable as risky behaviours like pregnancy, use and abuse of drugs and the drinking of alcohol will continue to be a problem in secondary schools. Understanding what knowledge and what attitudes students have in relation to HIV and AIDS might inform how relevant stakeholders can package resource material to accommodate the developmental stage of students at junior secondary schools in Botswana. Students continue to display risky behaviours though they are knowledgeable of the effects of contracting HIV/AIDS. Young people at this stage are risk takers. The act of falling pregnant

indicates a risky behaviour as one would have engaged in an unprotected sexual encounter hence putting them at a risk of getting infected in the process.

Regionally, a number of studies have been carried out to explore the relationship between youth and HIV and AIDS. For example studies such as Dita & Bodilsen (2018) in Sudan, Kitila & Mkumbo (2013) in Tanzania, Adbpye, Youngsong Akinwumi & James (2016) in South Africa, Gudyanga & Mashini, Gudyanga (2014) in Zimbabwe, Butts et al (2018) Bwalya, Banda, Jere, Patrick Amanzi & Funsani (2015) in Zambia, (Magowe, Seloilwe, Dithole & Lawrence (2017) Kgomotso, Garegae, Mogotsi & Gobagoba (2017)in Botswana, and Mwamwenda (2013)in Kenya have discussed HIV and AIDS and the youth. Most of these studies note a discrepancy between knowledge, behaviour and attitude among youth. For example, Mwamwenda's (2013) found out that unlike most similar studies, there was a correlation between transfer of knowledge and change in behaviour. Gonclaves et. al (2013) carried out a study in Southern Brazil among eleven year olds through a self-administered questionnaire using a sample of 3949 pupils. The objective of the study was to establish the knowledge of the pupils on HIV and AIDS. This particular study found out that knowledge was lower among boys than girls. Such a study is therefore important because more effort is needed to improve the level of knowledge among boys, since culturally men have more power in decision making in relation to sexual issues. Another study was carried out in Nigeria among senior secondary schools to assess the knowledge on HIV and AIDS and their sources of information (Bamise, Bamise & Adediqba 2011). Participants were identified through a multi-stage sampling where 592 students responded to a self-administered questionnaire. The study found out that though students had adequate knowledge about HIV and AIDS (50%), there were some who depicted inadequate knowledge such as that mosquitoes can transmit HIV and AIDS. Ellece (2016) analysed the BAIS IV statistics and concludes that 'young women aged 15-19 are not having sexual relations with men of their age because their age mates have 0% prevalence rate' (2016, p.273).The study further concluded that students still harbour a lot of misconceptions about HIV and AIDS. This study contributes to the debate on HIV and AIDS among students who are almost 'between and betwixt' stages as they complete the final year of junior school and about to enter senior secondary school. These students are at the peak of their teenage years.

Theoretical considerations

Kombo & Tromp explain that the theoretical framework is important because it '...uses a theory to account for and clarify why things are the way they are,' (2006, p.56). A number of behavioural theories, usually referred to as Behavioural Decision Making (BDM) have been adopted to explain and predict behaviour, explain beliefs and attitudes. These theories 'are largely concerned with the cognitive process by which humans perceive, structure and evaluate courses of action (Holtgrave, Tinsley & Kay, 1995, p.25). Denison lists the following as the four major theories of behaviour: the Health Belief Model; AIDS Risk Reduction Model, Stages of Change Theory and the Theory of Reasoned Action (1996). Denison explains further that all these theories try to answer the question; how does one change behaviour? These theories have specific human attributes to predict behaviour: The Health Belief model focuses

on the attitudes and beliefs on the individual; the AIDS Risk Reduction Model (ARRM) focuses on the recognition and labelling of one's behaviour as high risk, commitment and action; stages of Change Theory focuses on identifying the psychosocial stage at which the individual is, in terms of HIV and AIDS, pre-contemplation, contemplation and action, while the fourth stage, the Theory of Reasoned Action, is based on the premise that people are rational beings therefore their actions are reasoned, (1996). Of the four theories I find the Stages of Change theory to be more relevant in counselling programmes, for instance, hospitals, counselling clinics since the customers might already be infected therefore in need of counselling. In a Junior School emphasis should be more on making students to be aware of the risk behaviours associated with HIV infection and help them to effectively assess their own behaviour in relation to its riskiness. The Health Belief Model will partially explain the attitudes that students have while the ARRM focuses on the knowledge aspect. This paper will make use of the Health Belief model and the ARRM. The next section discusses each of the models.

AIDS Risk Reduction Model

The ARRM seeks to establish the extent to which learners perceive themselves as 'actually at a risk of being infected with HIV and AIDS and what they know of HIV and AIDS related issues,' (Fisher & Fisher 2000). The ARRM focuses on the individual who is very important in behavioural change.

The Health Belief model (HBM)

According to Tarkang & Zotor the HBM was first developed during the early 1950s in the United States of America by psychologists Godfrey Hochbaum, Irwin Rosenstock and Stephen Regels working in the US public health service. The model was developed in response to the failure of a free Tuberculosis (TB) health screening programme (2015, p.2). The model makes a number of assumptions;

The HBM assumes that a person will take a health related action if that person feels that a negative health condition can be avoided. It is necessary to help individuals realise that they have the potential to avoid a condition and this can only happen when one has true knowledge of the problem. It is only when one realises this, that one would be able to take a preventative action. The HBM also assumes that a person will take preventative action if that person has a positive expectation that by taking a recommended action, the negative health condition will be avoided.

The person needs to see the benefits that one will get from practicing the behaviour. If a person fails to see any benefit, it would be difficult for one to take the necessary action, or to maintain it. Students in the current study must perceive the benefits of male condoms, before they can initiate and maintain their use in order to prevent HIV/AIDS. The HBM also assumes that a person takes a health related action if the person believes that one can successfully take the recommended action. It requires the person to feel confident that one has the capacity to take the recommended action, and this would require that the person has the necessary knowledge and skills in a supportive

environment to carry out the required action(s).' (Tarkang & Zotor 2015, p.2; Stretcher & Rosenbeck 1997)

The HBM has three components: The individual's perceptions about health (that is, the extent to which one sees themselves as at risk of contracting a disease), the modifying factors which include demographic, socio-psychological and structural variables and the benefits of taking preventive measures (Tarkang & Zotor 2015, p2; Stretcher & Rosenbeck 1997).

It is therefore important to understand the extent to which students at junior schools in Kweneng and Central Districts perceive themselves as vulnerable to contracting HIV and AIDS. Understanding the self-diagnosis of vulnerability in relation to HIV and AIDS is important as it has a bearing on how one relates to those already affected by the disease. If students perceive HIV and AIDS as self-inflicted, then they are highly likely to stigmatise a classmate with a condition or force him or her to hide when taking their medication, thereby compromising compliance. The theory has a number of modifying factors. Modifying factors are those 'things' that would impact on the effectiveness of the theory. For HBM some demographic factors like age, sex culture are significant (for more factors see also Tarkang & Zotor 2015, p4)

The two theories complement each other and will effectively be used as a tool of analysis in this study. Over and above this the theories have been empirically tested as they have been used in other HIV studies (Tarkang & Zotor, 2015) and the ARRM (DiClemente, 1996).

Statement of the Problem

HIV and AIDS has been a problem in Botswana for a long time despite the many intervention programmes that the government has put in place. The government has disseminated information and provided services but there is still evidence of new cases and students in secondary schools still drop out of school due to pregnancy. Many scholars in behavioural change especially in areas concerning HIV and AIDS have noted with concern that knowledge alone does not always translate to behavioural change. Regardless of tremendous efforts that the government of Botswana has put in place, there is evidence that adolescents still continue to display risky behaviours which could result in them contracting HIV and AIDS. Therefore it is important to consistently 'check' what students know and think about HIV and AIDS.

Methodology

Data is from a study that I carried out when evaluating the Peace Corp project in selected junior schools in Botswana. I used a mixed methodology approach. However for the purpose of this paper I selected the quantitative data from 6 junior secondary schools in Kweneng and Central Districts. All research protocol was followed for ethical clearance including consent and assent form. A total of 602 students attempted the questions in all the six schools. After screening and cleaning of data, 450 questionnaires were valid. Descriptive analysis was used to illustrate the knowledge and attitudes of form 3 students. I personally administered the questionnaire except in two schools.

Variables of interest

My two variables of interest are knowledge and attitudes of students in their final year of junior secondary schools in Botswana. The knowledge variable is defined by the following items: *It is possible for me to contract HIV* and *can people reduce their chances of getting HIV and AIDS by having one uninfected partner who has no other partners*.

The attitudes variable is defined by the items: *AIDs patients suffer the consequences of their immoral lives* and *if my sister or brother has HIV I would like it to remain a family secret*.

Knowledge variable

Table 1: *Is it possible for me to contract HIV and AIDS*

		Frequency	Percent
Valid	STRONGLY DISAGREE	78	17.3
	DISAGREE	54	12.0
	DONT KNOW	74	16.4
	AGREE	142	31.6
	STRONGLY AGREE	92	20.4
	MISSING	10	2.2
	Total	450	100.0

450 students responded to the item. A total of 132 (i.e. a total of students who *strongly disagree* 978) and *disagree* (54) students (29.3%) do not think they can get infection. It is worrisome that despite all the information disseminated in schools about HIV and AIDs there are still students who perceive themselves as immune from HIV and AIDS. Such a position is not safe as students might engage in unsafe sex with the view that they cannot get infected with HIV and AIDS. Over and above the numbers of students who believe they cannot contract HIV and AIDS 74 (16.4 %) do not know if they can or cannot contract the virus. This level of ignorance is a danger to students as they are likely not to take decisions or action to protect themselves from infection. However, slightly more than half 234 (52 %) know that it is possible for them to get infected.

Table 2: Can people reduce their chances of getting HIV and AIDS by having one uninfected partner who has no other partners

		Frequency	Percent
Valid	STRONGLY DISAGREE	57	12.7
	DISAGREE	49	10.9
	DONT KNOW	89	19.8
	AGREE	134	29.8
	STRONGLY AGREE	115	25.6
	MISSING	6	1.3
	Total	450	100.0

450 students responded to the item. The majority 249 (55%) (a total of those who *agree* (134) and *strongly agree* (115) know that one way of protecting oneself from contracting HIV and AIDS is to have one sexual partner who is HIV negative and has no other partner. 106 (24%) students (those who *Strongly disagree* (57) and *disagree* (49)) lack this factual knowledge while 29 (20%) *don't know*. Many students have knowledge on how they can prevent themselves from HIV and AIDS. It is worrisome that after all the resources that are available to students and the nation at large there are still some individuals who do not know how to protect themselves from HIV and AIDS.

Attitudes Variable

Table 3: AIDS patients suffer the consequences of their immoral lives.

		Frequency	Percent
Valid	STRONGLY DISAGREE	65	14.4
	DISAGREE	104	23.1
	DONT KNOW	101	22.4
	AGREE	126	28.0
	STRONGLY AGREE	46	10.2
	MISSING	7	1.6
	Total	449	99.8
Missing	System	1	.2
Total		450	100.0

Of the 450 students who responded a total of 169 (37.6 %) (a total of those who *strongly disagree* 65 and *disagree* 104) portray a positive view towards people living with HIV and AIDS. They understand that not all cases of HIV and AIDS are a result of a careless sexual life style. However that a slightly higher number 172 (38%) (a total of those who *agree* 126 and those who *strongly disagree* 46) say people living with HIV and AIDS are reaping the results

of their immoral acts is an indication of how stigma towards people living with HIV and AIDS will not fade any time soon. This shows that some students have negative attitudes towards people living with HIV and AIDS. This negative attitude can be probably due to insufficient knowledge on the subject. A combination of factors contributes to such attitude. In most African societies sex talk is usually very minimal between adults and children. This results in children lacking clarification on crucial information relating to sex and sexually transmitted illnesses. The negative attitude might also be related to the secrecy surrounding sex and sexuality. 101 respondents (22.4%) do not know whether people living with HIV and AIDS suffer the effects of their immoral lives or not.

To get a clearer picture on the attitude of students towards HIV and AIDS they were asked to express their perceptions on HIV and AIDS within their family set up. Their responses below poignantly captures the current attitudes held by students completing their final year of junior secondary school.

Table 4: *If my sister or brother has HIV I would like it to remain a family secret.*

		Frequency	Percent
Valid	STRONGLY DISAGREE	51	11.3
	DISAGREE	58	12.9
	DONT KNOW	57	12.7
	AGREE	134	29.8
	STRONGLY AGREE	144	32.0
	MISSING	6	1.3
	Total	450	100.0

A whopping 278 out of 450 (61.8%) (*agree* 134 and *strongly agree* 144) do not want the world to know that their siblings are living with HIV and AIDS. They want such information to remain a family secret. This shows a negative attitude, shame and stigma in relation to HIV and AIDS. Only 109 (25.8%) (*Strongly disagree* 51 and *agree* 50) students of the 450 feel it is ok not to keep the HIV status of a sibling a secret. Garegare, Mogotsi & Gobagoba (2017) when comparing BAIS II and IV statistics of the attitudes of students in Botswana on whether a student will allow a teacher with HIV and AIDS to continue teaching, found a significant level of tolerance over time. Similarly in this study, though students portray fewer stigmas in general towards people with HIV and AIDs, they find it difficult or more shameful if one with HIV is a close member of the family. This has implications on the day to day lives of patients at home as they might be stigmatised by their own.

Discussions

A significant 132 (29%) out of the 450 students do not perceive themselves as vulnerable to HIV infection with 74 (16.4%) not knowing whether they can contract HIV or not. The two theories adopted for this paper, ARRM and HBM, explain that for any positive change in behaviour to take place, an individual needs to acknowledge their vulnerability. The fact that some perceive themselves as immune to HIV infection partially explains the ever increasing

teenage pregnancies in schools. Some students are likely not to protect themselves from infection as they do not believe that they can be infected. This is the case despite the knowledge that they have. The paper further concludes that it is a concern that students doing Form three have negative attitudes or stigmatise the disease as reflected in their desire to keep the status of an HIV positive sibling a family secret. This is likely due to the general stigma by societies on HIV and AIDS. These attitudes need to be addressed because they have an impact on;

- How students relate with peers who are living with HIV and AIDS in schools.
- How students with HIV and AIDS would feel in the school environment: (problems in taking medication or withdrawal from school activities are likely and this can raise issues of compliance to medication when a student is on a school trip, for instance).
- The negative attitude will also affect the possibility of disclosure after diagnosis.

Conclusions and Recommendations

This paper concludes that though the government of Botswana has made efforts to educate students on HIV and AIDS lack of knowledge and ignorance is still a problem among the Form three students. Stigma and secrecy are still a problem. There is need to fill in this knowledge gap. Therefore I recommend that the government should continue to educate students on HIV and AIDS with the primary focus on addressing issues of stigma, acceptance and perceptions about HIV and AIDS. This could be achieved by utilising the already existing structures like schools, clinics, churches and departments since manpower with relevant skills already exists in these facilities, a life skills education can be infused effectively. Furthermore having HIV and AIDS issues as a subject vs. infusion might go a long way to address the current knowledge gaps and the attitude that students have taken.

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