EXPLORING THE STATUS OF HIV/AIDS RELATED STIGMA AMONG STUDENTS IN BOTSWANA LEARNING INSTITUTIONS: A COMPARISON OF BAIS II AND BAIS IV

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Abstract

This paper explores the extent to which HIV/AIDS related stigma has increased or decreased amongst students in Botswana institutions of learning over a period of 8 years. Using the responses from the individual questionnaire from both the BAIS II of 2004 and BAIS IV of 2012 surveys, the study investigated whether or not students would allow a teacher living with HIV to continue with his/her work. The participants were aged between 10 and 24at the time of the study. Chi-square and logistic regression were used to navigate the data. The results of the study show a significant increase of tolerance towards a teacher living with HIV. Though difference due to places of residence, level of schooling and gender are similar to those in 2004, generally, negative attitudes decreased over the years. These positive findings may be attributed to the fact that HIV/AIDS education is infused in the Botswana curriculum right from primary school to tertiary, TV presentations and other educational programs. However, learning environment in Botswana learning institutions may not be safe for the infected and/or affected because of stigma and discrimination.

Keywords: HIV/AIDS related stigma, HIV/AIDS related discrimination, student-teacher interaction, student-student interaction, learning environment

1.0 Introduction

The term stigma has traditionally been used to refer to a mark burned on the body of a slave to distinguish him/her from other people (Herek, 2007). According to Herek, slaves were viewed as having low dignity. Stigma is now used as a mark of shame and derogatory status. Thus, social stigma reduces victims to lower status, even to the extent of disrespecting their human rights. The results of this stigmatization include eroded self-image and feelings of insignificance and insecurity. Stigmatization is engrained in the human race; people may be victimized because of natural attributes such as race and ethnicity. Even patients suffering from diseases caused by socially unacceptable behaviours such as promiscuity may be stigmatized and/or prejudiced against. In this article, discrimination refers to prejudice against people because of ethnicity, religion, or any categorical basis including socio-economic status, physically and mentally challenged, the type of illness one is suffering from e. g. syphilis and AIDS.

HIV/AIDS related stigma and bias emanating from it may have a negative impact on social and economic activities. According to Kassile, Anicetus and Kukula (2015), HIV/

AIDS related stigma and discrimination can undermine the effectiveness of national efforts designed to prevent and control the HIV epidemic because they are barriers to any intervention measures. People who are HIV positive and those already suffering from AIDS experience differential treatment both at home and in the workplace. For example, some people who are affected or infected by the HIV/AIDS pandemic maybe excluded from normal activities; they might be given a less workload, have less or no interaction in terms of physical contact and may be isolated from discussions about life in general and the future in particular, among other things. In most cases such differential treatment causes these people to feel insignificant, insecure and stigmatised.

The impact of stigma and discrimination on social activities has been observed in Botswana as well. These attitudes and behaviours are reported to have hampered government interventions such as Anti-Retroviral (ARV) Therapy, Prevention of Mother to Child Transmission (PMTCT) and Isoniazid Preventive Therapy (IPT) as well as the feeding programs (Republic of Botswana, 2004). The third President of Botswana, His Excellency former President Festus GontebanyeMogae, said "the stigma surrounding the disease remains one of the greatest barriers to the implementation of various care and prevention strategies" (Republic of Botswana, 2004: 53). This stigma also slows down the rate at which people undergo voluntary testing, an act that is contrary to the government's wish. It is because of this reason that this study was conceived. It is feared that stigma and discrimination, if allowed in learning institutions, may impede the teaching and learning process.

Discrimination in the classroom, just like discrimination in the workplace (Kassile, Anicetus & Kukula, 2015) may hamper the learning process because in an ideal classroom situation, students interact freely in order to negotiate and share meanings among themselves and with the teacher (Blumer, 1986; Kumpulainen & Wray, 2002). In this interaction process, people are sometimes 'forced' to make physical contact, especially in a Mathematics (Cobb, Yackel & Wood, 1992), Integrated Science (Chin, 2006; Lee, Fraser & Fisher, 2003), Design and Technology (D&T) and Home Economics (HE) class. If classmates and or the teacher discriminate against a student, it would be difficult for that student to benefit from the learning process. It is therefore important that HIV/AIDS related stigma and discrimination be reduced and ultimately eliminated in schools (Adelekan & Edoni, 2012; Republic of Botswana, 2012) and the society at large.

What is disheartening however, is the report by the 2004 Botswana AIDS Impact Survey (BAIS) II results which indicate that, discrimination associated with HIV/AIDS possibly exists in Botswana schools. Garegae and Gobagoba (2005), who studied BAIS II data dealing with an infected teacher, found that students aged between 10 and 24 discriminated against those affected or infected with the epidemic. Garegae and Gobagoba (2005) examined this differential treatment on the basis of location, sex and level of education, and observed that students from rural areas were more prejudiced than those in urban areas; and those in the lower levels of education showed more discriminator attitudes than those with higher education levels. This study is a follow up on Garegae and Gobagoba (2005), and seeks to find out whether the discriminatory attitudes have decreased or otherwise over a period of 8 years.

2.0 Background

Botswana is one of the leading countries with regards to the HIV/AIDS pandemic in Southern Africa. The death toll is at an all-time high, and almost every household is affected. Ever since the identification of the first victim in 1985, the spread of HIV has been dramatic, and has caused havoc in the country. This rapid spread of the HIV infection can be attributed to social and telecommunication factors (Republic of Botswana, 1998; 2009). Batswana typically have a place of abode in urban/semi-urban and rural areas. It is a plausible habit that, especially males may have (a) partner(s) in all of these places, predisposing them to HIV

infection. In addition, socio-economic factors, denial and cultural beliefs about HIV/AIDS also contribute to this rapid spread (Republic of Botswana, 2012).

The 1999 statistics showed that 17% of the total population of Botswana was infected with the HIV virus, and that 29% was in the sexually active cohort (Republic of Botswana, 2001). The 2003 second generation HIV/AIDS surveillance data reported that children aged between 14 –19 are at higher risk than other age ranges, and that teenage pregnancy is one of the main factors leading to school dropout—implying that these students engage in unprotected sex. The statistics further indicated that the number of students who leave school because of illnesses and deaths is increasing yearly, with HIV/AIDS being plausibly one of the diseases. Furthermore, the 2004 BAIS II showed that approximately 40% of young people are living with HIV, with the most affected districts being Chobe, North East and Kgalagadi, in that order (Republic of Botswana, 2005b).

Because of the reports mentioned above, and many others, the government of Botswana decided to make it a priority that people were informed about HIV/AIDS. Several interventions were made by different government departments, targeting especially adolescents. Various transmission methods, such as school curricular, TV shows and many others were used. In addition, The Ministry of Education and Skills Development strategic framework for HIV-AIDS 2011-2016, enabled the Ministry to find ways of mitigating the negative impact of HIV/AIDS on the education sector (Republic of Botswana, 2012).The infusion of HIV/AIDS issues into the school curriculum was one method of educating the nation, targeting especially future generations.

In addition to the school curriculum, *Talk Back*, a TV programme, *Ntwakgolo*, a docu-dramaand *Makgabaneng*, a radio programme, are means through which the government transmitted HIV and AIDS related information to Batswana. *Morwalela*, the edutainment TV series, provides continued encouragement to people living with HIV and motivates them to live healthy lives and to adhere to treatments and prescribed medication faithfully. These initiatives target young people, especially school going children and middle-aged adults because these age cohorts are the mostly affected. Local artists have also started composing songs on HIV/AIDS, contributing to the many forms of information delivery on HIV/AIDS. The hope is that the stigma associated with this virus and disease together with the associated prejudices will gradually decrease.

In a learning environment, student-student or teacher-student interactions are inevitable. Such interactions may provoke different kinds of physical contact in subjects like Mathematics, Integrated Science, D&T and HE, where sharp instruments are used. HE, for instance, is a practical subject where students are required to engage in hands-on activities, and thus always share equipment as they prepare food and sew garments (Republic of Botswana, 2013). Sharp objects such as knives, scissors and seam rippers are used often. The use of these tools predisposes teachers and their students to safety accidents, and in the era of HIV/AIDS, First Aid help from classmates may not be expected and/or administered. Also, those perceived or known to be infected may be side-lined with regard to equipment sharing (Kasapoglu, Saillard, Kaya & Turan, 2011). In all of these classes, the teachers cannot avoid physical contact with students because of the need to check progress and offer assistance where necessary. This is also a risk factor for the teachers.

Most of the existing literature on HIV/AIDS related stigma and discrimination was conducted in the workplace (Kasapoglu, et al., 2011; Francis & Francis, 2006). There is meagre literature on the impact of stigma and discrimination in Botswana schools. Any literature on this area pertains to the quality of education and the amount of learning taking place as a result of the HIV/AIDS pandemic (Barnett & Whitehead, 2002; Gachuhi, 1999). Generally, the quality of education is significantly affected because of teacher/student absenteeism due

to ill health; and most often replacement for a sick teacher is not possible or immediate. As mentioned above, Garegae and Gobagoba (2005) studied BAIS II data with regard to an infected teacher, and examined differential treatment in light of location, sex and level of education. The current study is a follow up on Garegae and Gobagoba (2005) and seeks to find out whether prejudiced attitudes among learners have decreased or otherwise over a period of 8 years. This paper specifically seeks to study the following:

a) Does HIV/AIDS related stigma (still) exist among primary, secondary and tertiary students in Botswana schools?
b) Has the HIV/AIDS related stigma decreased/increased over the past 8 years?

3.0 Theoretical framework

Basing on the assumption that no classroom interaction takes place in a vacuum, but is embedded in the socio-cultural context in which activities are shaped by the teacher and students (Kumpulainen & Wray, 2002), this study uses Symbolic Interaction Perspective (SIF) as its Theoretical Framework. According to Blumer (1986), SIF is about the construction and reconstruction of meaning between and among people as they interact on daily basis. It posits that meanings are socially constructed and mutually defined. Meanings about HIV and AIDS are socially constructed and mediated through symbolic cues mutually defined by actors. In the process of classroom interaction these meanings are interpreted, enacted, and represented in concrete or abstract symbolic forms (Kaiser, 1997). Symbols are resultants of social interaction and they "help to initiate responses, provide cues to behaviour, organize behaviour, focus our attention on critical elements in a social situation, and permit us to organize our behaviour as appropriate" (Kaiser, 1997, p. 42). For example, in Botswana, sometimes only a citizen may understand *a language cue* or 'connotation' used in relation to issues associated with HIV/AIDS. For instance, the common languages cues for AIDS are *mabele a kgomo*, (a cow's teats), *Route* 4, referring to the four letters of the disease—A-I-D-S.

Bearing in mind the high level of interaction displayed in symbolic perspective, we find this line of thinking to be a good framework to guide this study in relation to Mathematics, D&T, Integrated Science and Home Economics classroom interactions. In Mathematics teaching and learning for example, interaction necessitates closeness and physical contact among students and between the teacher and the learner. It requires social interaction, humane, friendliness and understanding, thus predisposing mutual communication. Actors are engaged in a process of meaning negotiations influenced by social relations, social system(s), values and culture, which are basically the understanding of mathematical knowledge. This social action becomes an experience for the two people interacting, which could result in love, shame and embarrassment. These social acts represent attitudes, gestures and language use that elicit specific responses from the other, which are interpretations that convey meanings to another person (Blumer, 1986). The interpretations as social acts that represent interaction between the infected/affected and classmates are connected to norms, values and social roles in the mathematics classroom.

Since HIV/AIDS stigma is associated with discrimination, both the teacher and students could express different attitudes and gestures that alienate the HIV/AIDS infected/affected student. As the student is also part of the society, he/she is aware of the symbolic meanings attached to these enacted acts, and may react either positively or negatively, in response to the teacher and his/her classmates. This study explores the learning environment in Botswana learning institutions in regard to HIV related stigma and discrimination.

4.0 Methodology

4.1 Participants

The population of this study were respondents aged between 10 and 24 by the time of the study in 2012 and was thus classified as students. They were further divided into four categories: Primary (10-14 years), Junior Secondary (15-17 years), Senior Secondary (18 -19 years) and Tertiary (20-24 years). Those in the category of Primary and Junior Secondary did not participate in the 2004 BAIS II because their ages ranged from 2 to 9; the rest of the participants ranged from 10 to 16 years, indicating that they were roughly in Upper Primary up to Form 2 in 2004, and would be participating in the survey for the second time.

4.2 Data manipulation and analysis

Data used in this article were from Individual Questionnaire entries of both BAIS II and BAIS IV on the question of whether a teacher living with HIV should or should not continue to teach. The results for BAIS II and BAIS VI are compared. More than 419 000 (40.6%) students who participated in BAIS IV 2012 and 323 000 (46.2%) from 2004 BAIS II responded to the questionnaires used in this study (Cf. Republic of Botswana 2005a). Entries of both BAIS II and BAIS IV were subjected to Chi-Square tests and Logistic Regression Model to find relations among variables as well as finding out the extent to which independent variables influence the dependent variable. The covariates were: age of the participant, level of schooling, place of residence, gender, respondent's willingness to share food with an HIV positive person, buying from an HIV positive shopkeeper and keeping secret the HIV status of a relative.

5.0 Findings

The findings are presented according to the research questions.

5.1 *Does HIV/AIDS related stigma (still) exist among primary, secondary and tertiary students in Botswana schools?*

The first question sought to find out whether HIV/AIDS related stigma still existed among primary, secondary and tertiary students in Botswana schools. The covariates explored included (1) level of schooling, (2) sex of students, (3) a place of residence, (4) whether or not a person living with HIV may look healthy, (5) whether or not participants can share food with HIV and (6) whether or not participants can buy from a shopkeeper living with HIV. The results are discussed below.

5.1.1 *Level of schooling*

Table 1 segregates the student population into Primary, Junior Secondary, Senior Secondary and Tertiary. Generally, the 2012 results show that about 85% of student population would allow an HIV positive teacher to teach while only 15% indicated otherwise. The results further show that Upper Primary students (70.9%) are less likely to allow a teacher living with HIV to continue his or her work than their counterparts.

Table 1: Comparison of students' attitudes towards an HIV+ teacher by level of education

Level of Education	Should an HIV+ teacher continue to teach?	
	2012	
	YES	NO
Primary (10-14)A	70.9	29.1
Junior Secondary (15-17)	90.8	9.2
Senior secondary (18-19)	93.7	6.3
Tertiary (20-24)	93.0	7.0

$X^2 = 34611.74$, df = 3, $p<0.001$

5.1.2 *Sex of students*

Table 2 indicates that in 2012 83% of males said they would allow an HIV positive teacher to continue teaching. The difference is highly significant (less than 1%) with a chi-square of 2571. It is observed further that 88.5% of females are more tolerant to a teacher who is HIV positive than their male counterparts at (83%).

Table 2: Comparison of students' attitudes towards an HIV+ teacher by of respondent's sex

Sex of respondent	Should an HIV+ teacher continue to teach?	
	2012	
	YES	NO
Male	83.0	17.0
Female	88.5	11.5

$X^2 = 2571.3$, df =1, $p<0.001$

5.1.3 *Place of residence*

Table 3 shows that students who reside in rural areas are less likely to allow an HIC positive teacher to continue teaching. Only 83% of them are tolerant compared to 92% of those living in the city who can allow such a teacher to continue with his work.

Table 3: Comparison of students' attitudes towards an HIV+ teacher by locality of abode

Locality	Should an HIV+ teacher continue to teach?	
	2012	
	YES	NO
Cities	92.0	8.0
Towns	91.3	8.7
Urban Villages	85.0	15.0
Rural	83.2	16.0

$X^2 = 3725.67$, df =3, $p<0.001$

5.1.4 *Looking healthy while HIV positive*

Table 4 below indicates that 91% of students who believe that a person living with HIV may look healthy would allow an HIV positive teacher to continue teaching.

Table 4: Comparison of students' attitudes towards an HIV+ teacher by respondent's belief that HIV+ person may look healthy

Is it possible for a healthy looking person to have HIV?	Should an HIV+ teacher continue to teach?	
	2012	
	YES	NO
Yes	91.1	8.9
No	73.2	26.8
Don't know	65.3	34.7

X^2 = 26894.03, df =2, p<0.001

5.1.5 *Sharing food with an HIV positive person*

Table 5 shows that in 2012, 70.9% of those who indicated that they would share food with an HIV positive person said an HIV positive should be allowed to teach.

Table 5: Comparison of students' attitudes towards an HIV+ teacher by of respondent's willingness to share food with HIV+ person

Would you share a meal with a person who has HIV/AIDS? (Q601)	Should an HIV+ teacher continue to teach?	
	2012	
	YES	NO
Yes	95.2	4.2
No	64.2	35.8

X^2 = 70046.241,df =1, p<0.001

5.1.6 *Buying from an HIV positive shopkeeper*

In Table 6, 95.9% of students who would buy from an HIV positive shopkeeper said the teacher should be allowed to teach.

Table 6: Comparison of students' attitudes towards an HIV+ teacher by respondent's willingness to buy from an HIV+ shopkeeper

If you knew that a shopkeeper or food seller had HIV or AIDS, would you buy vegetables from them?	Should an HIV+ teacher continue to teach?	
	2012	
	YES	NO
Yes	95.9	4.1
No	55.6	44.4

X^2 =105066.59,df =2, p<0.005

The results presented in Tables 1 to 6 indicate that even after a period of 8 years, HIV/AIDS related stigma still existed in primary, secondary and tertiary institutions in Botswana.

5.2 Has the HIV/AIDS related stigma decreased/increased over the past 8 years?

The second question sought to find out whether the HIV/AIDS related stigma has decreased or increased between 2004 and 2012. The findings are presented in Tables 7 and 8.

Table 7: Status of stigma across level of schooling, locality and students' sex (%)

	Level of schooling				Locality				Sex	
	Primary	Junior Secondary	Senior Secondary	Tertiary	Cities	Towns	Urban villages	Rural	Male	Female
2004	42.8	65.4	74.1	79.2	79.3	79.9	69.0	51.3	59.5	69.1
2012	70.9	90.8	93.7	93.0	92.0	91.3	85.0	83.2	83.0	88.5
% increase	28.1	25.4	19.6	11.8	12.7	12.3	16	31.9	23.5	19.4

From Table 7, it is observed that, at 70.9% tolerance, there has been a remarkable percentage increase of tolerance (28.1%) among Upper Primary learners in 2012 compared to 42.8% in 2004. Furthermore, the other levels, Junior and Senior Secondary Schools as well as Tertiary, recorded an increase of over 10% minimum. However, it is observed that in 2004 the extent to which students were tolerant of an HIV positive teacher increased with the level of education but in 2012 a slight decrease was noticed between Senior Secondary (93.7%) and Tertiary (93%).

A percentage increase of over 30 is observed among students residing in rural areas and there is an overall improvement of students' attitudes towards people living with HIV over the past eight years across places of residence. In 2012, 92% of students in cities, 91.3% in towns, 85% in urban villages and 83.2% in rural areas said they would allow an HIV positive teacher to continue with his or her job. A notable increase is observed with rural students. In 2004 51% of them said they who would allow the teacher to continue with his or her work. Eight years later, 83% of them reported likewise, recording a 32% increase.

Table 7 also shows an increase of 20% in change of attitude in male students. Further, in 2012, 88.5% of females, as opposed to 69.1% in 2004, said they would allow the HIV positive teacher to teach. Overall, the results show that females are more tolerant than their male counterparts.

Table 8 shows that between 2004 and 2012 there has been a decrease in the negative attitudes towards a teacher living with HIV. In 2012 about 91% of students who said they would allow a HIV positive teacher to continue teaching indicated that there is a possibility that the HIV positive individual may look healthy. In 2004, only 71.5% of these students said they would allow the teacher to continue teaching. This is a percentage increase of about 20%. Students who said they would share a meal with such a person also increased by 11%; and those who would buy from an HIV positive shopkeeper said the teacher should be allowed to teach increased by 7%.

Table 8: Nature of interaction with an HIV+ person (%)

	Possibility of a HIV+ person looking healthy	Sharing a meal with a HIV+ person	Buying vegetables from HIV+ person
2004	71.5	84.3	88.9
2012	91.1	95.2	95.9
% increase	19.6	10.9	7.0

The results summarised in tables 7 and 8 confirm that HIV related stigma have decreased from 2004 to 2012.

5.3 Further analysis

The results of logistic regression confirm findings obtained from chi-square in both 2004 and 2012 data sets as observed in Table 9. Primary students are, significantly, five times (5.441) more likely to discriminate against an HIV positive teacher than tertiary students, and are followed by Junior Secondary School students with an odd ratio of 1.345. Senior Secondary School students are 11% less likely to discriminate against the HIV positive teacher when compared to tertiary students. The odd ratio of 0.890 corroborates the Chi-square results where 93.7% of Senior Secondary students said they would allow an HIV positive teacher to continue teaching, as opposed to 93% for tertiary students.

Students who indicated their unwillingness to share food with people living with HIV are 11 times more likely to stigmatise a teacher living with HIV than those who are prepared to share food with an HIV positive person. There has been a significant decrease in negative attitudes towards such a teacher since 2004, except in one covariate, buying from an HIV infected shopkeeper. Whereas in 2004 (Cf. Table 9) the odds ratio for buying from an HIV infected shopkeeper was 11.769 in 2004, in 2012 it was 18.782, indicating a negative increase by 7.013. These results, however, need further exploration since they contradict previous studies which have shown that people tend to accept people living with HIV over time (Baumgartner, 2012).

Table 9 presents logistic regression predicting students' attitudes towards an HIV positive teacher for both 2004 and 2012 data.

Table 9: Logistic regression predicting students' attitudes towards an HIV infected teacher: a comparison (BAIS IV and BAIS II)

		BIAIS IV 2012	BIAIS II 2004
Variable		Odds ratio	Odds ratio
Level of schooling	Primary	5.441	5.235***
	Junior Secondary	1.345	2.078
	Senior secondary	0.890	1.545
	tertiary	1.000	1.000
Place of residence	Cities	0.429	0.274
	Towns	0.469	0.266
	Urban villages	0.869	0.473
	Rural	1.00	1.000
Sex of respondent	Male	1.000	1.000
	Female	0.636	0.655***
Respondent's willing to share a meal with an HIV person (Q601)	Yes	1.000	1.000
	N0	11.131	3.174***
Buying from an HIV positive shop-keeper (Q605)	Yes	1.000	1.00
	No	18.782	11.769***
Keeping secret relative's HIV status (Q606)	Yes	1.000	1.000
	No	1.712	0.866***

*** Significant at 1%

6.0 Implications of the findings for the Symbolic Interaction Framework

It was noted above that the construction and reconstruction of meaning among people as they interact on daily basis is one of the tenets of the Symbolic Interaction Framework (SIF) (Blumer, 1986). According to SIF, meanings are socially constructed and mediated through symbolic cues which are mutually defined. Further, these meanings are interpreted, enacted, and represented in concrete or abstract symbolic forms during classroom interaction (Kaiser, 1997). In the context of the current investigation, although the findings of the study show a gradual decrease of negative attitudes, for the educator, the fact that stigma is still detectable in the learners means that such attitudes may be enacted in the classrooms (Kaiser, 1997). In a learning environment where group interaction in the classroom is inevitable, predominantly because learning is often facilitated through discussion and debate among and between students and teachers (Chin, 2006), enactment of existent bias becomes impending.

With regard to the HIV/AIDS stigma, verbal and non-verbal cues of acceptance or rejection would be conveyed to the infected and affected through the interpretative process (Kaiser, 1997; Blumer, 1986). The learners decode the cues by noting, interpreting words, spaces and silences and derive the meaning of acceptance or lack thereof. The intensity of rejection or acceptance would be understood through mutually defined cues, perhaps as modified by the cultural expectations and norms of respect or *botho* (humane) (Kumpulainen & Wray, 2002). However, students may try to conceal their prejudices even when it is evident. For instance, although 64% of participants who indicated that a teacher living with HIV should continue teaching, they also indicated that they are not willing to share meals with a person living with HIV. Another interesting, seemingly contradictory observation is that 55.6% of those willing to allow the teacher living with HIV to continue with work, showed their willingness to buy vegetables from the one infected with HIV. These mixed findings suggest that messages of acceptance or rejection might have to be derived through observation, as the idiom says '*actions speak louder their words'*.

In an environment where symbolic cues are constructed collectively, and mutually defined by the class, those discriminated against typically understand the cues as well (Blumer, 1986).This situation has implication for the learning environment, equity and equality in the education sector. Classrooms should provide ideal learning spaces and provide cordial environments where each student is valued, nurtured and respected (Lee, Fraser & Fisher, 2003). This would maximise learning for all. A prejudiced learning environment may produce little or no learning (Chin, 2006). Enacted attitudes may wear out the discriminated person to the point of dropping from school or leaving work, thus infringing into one's right to education/work.

7.0 Conclusion

The results of this study show that HIV/AIDS related stigma still exists in Botswana schools albeit at a lower rate than in 2004. The 2012 results indicate that students seem to be more ready to accept a teacher who is living with HIV than before, and to this end, a percentage increase of more than 30 has been recorded. These promising results could be attributed to various interventions offered by both the government and non-governmental organizations as stated elsewhere in this paper. The findings corroborate other studies which observed a positive correlation between knowledge about HIV/AIDS and reduction in stigmatisation (Baumgrtner, 2012; Adelekan & Edoni, 2012). However, the interventions should be continued and more done to help people to come to a comprehensive understanding of the HIV virus and how the AIDS disease develops. Efforts to engage students in poetry competitions, essay (Mwebi, 2012) and other avenues of information dissemination should be intensified. This will afford classroom interaction that is free from stigma and discrimination.

Although information about how HIV and AIDS is being delivered to the populace, it

seems integrating theory with experiential knowledge is a challenge to most young people as the current analysis shows. Perhaps students gave hypothetical responses derived from books, classrooms, etc. rather than genuine experiences. Phenomenological studies through which researchers could make an in-depth qualitative analysis of the issue at hand are therefore recommended. Such studies would give the government an idea on exactly how young people think and what influences their thinking at the time of decision making with regard to HIV and AIDS.

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