ATTITUDES OF YOUNG PEOPLE AGED 15ï 25 YEARS TOWARDS THE ñABCò STRATEGY IN THE PREVENTION OF HIV/AIDS IN FRANCISTOWN, BOTSWANA.

by

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DECLARATION

I declare that **ATTITUDES OF YOUNG PEOPLE AGED 15–25 YEARS TOWARDS THE "ABC" STRATEGY IN THE PREVENTION OF HIV/AIDS IN FRANCISTOWN, BOTSWANA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE **November 2010**

(Mrs JO Ezeahurukwe)

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ATTITUDES OF YOUNG PEOPLE AGED 15–25 YEARS TOWARDS THE "ABC" STRATEGY IN THE PREVENTION OF HIV/AIDS IN FRANCISTOWN, BOTSWANA

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ABSTRACT

A quantitative, descriptive and comparative study was conducted to determine the attitudes of young people aged 15-25 years towards the ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana. Differences between two age groups and gender were determined. Structured questionnaire was used and 241 young people participated in the study. Data were analysed with SPSS version 13.0, guided by the Health Belief Model. The findings revealed that young people did not perceive the seriousness and severity of the HIV/AIDS when it came to the practice of ñABCò strategy. Young peopleôs cue to action was very high but their confidence to adopt and practice the ñABCò strategy were low. They had adequate knowledge of the benefits of abstinence and condoms but they perceived barriers towards the use of condom. The differences between the two age groups, 15-19 and 20-25 years and between the males and females were not statistically significant.

KEY CONCEPTS: Abstinence, condom, faithfulness, young people, attitude, HIV/AIDS, ñABCò strategy, age group, male and female.

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LIST OF ABBREVIATIONS

ABC	Abstinence, Be faithful, Condom use
AIDS	Acquired Immunodeficiency Syndrome
CDC	Centres for Disease Control
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HSREC	Health Studies Research & Ethics Committee
KAP study	Knowledge, Attitude and Practice study
NGO	Non-Government Organization
PEPFAR	Presidential Emergency Plan For AIDS Relief
PTA	Parents/Teachers association
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations International Children`s Emergency Fund
UNISA	University of South Africa
USAID	United States Agency for International Development
WHO	World Health Organization
YOHO	Youth Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In 2007, it was estimated that more than 5.4 million young people between the ages 15 and 24 were infected with human immunodeficiency virus (HIV) globally. In addition, it was reported that young people aged 15-24 years accounted for about 45% of new HIV infections (Childinfo 2008). Sub-Saharan Africa is more affected by human immunodeficiency virus /acquired immunodeficiency syndrome (HIV/AIDS) than any other region in the world because, according to United Nations Children Emergency Fund (UNICEF) (2008) and Pembrey (2008), prevalence rates are highest in the region. Botswana is one of the sub-Saharan countries and its prevalence of HIV/AIDS among young people between the ages 15-24 is 15.3% of young women and 5.1% of young men living with HIV (Melles 2009).

The modes of transmission of HIV/AIDS are by heterosexual activity without precautions, intravenous drug users sharing needles or syringe containing blood from an infected person and HIV infected women who can transmit the virus to their new born babies (Kalra 2000:27). According to Lane and Palacio (2003:2) sexual contact is the most common route of HIV transmission. World Health Organization (WHO) (2006) reports that in 2001 over 90% of HIV infections in Africa were due to unsafe sex. Many young people in the age group 15-25 years engage in unsafe behaviour and significant numbers of them continue to be infected with HIV. Like in other sub-Saharan countries, the spread of HIV in Botswana is mainly through heterosexual sex and mother to child transmission (Rob 2008; Gisselquit and Potterat 2005:165).

AIDS is one of the biggest challenges facing the world today. It poses a serious threat to humans because the methods of treatment are generally ill-defined, complete cures are

non-existent and the majority of infected individuals are in danger of dying. Because there is no cure, prevention is important (Alcamo 2002:38).

According to Horizon report (2005), it is widely accepted that the ñABCò behaviour is key to preventing and reducing the sexual transmission of HIV. The prevention behaviour strategies, often referred to as the ñABCò of prevention are:

- **A** for abstinence
- **B** for being safer by being faithful to oneôs partner
- **C** for correct and consistent condom use (United States Agency for International Development (USAID) 2005).

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

Botswana is one of the countries in Southern Africa estimated at 581 730 square kilometres. According to the last census (2001), it has a population of about 1, 7 million. Of this population, 38% of the total population falls between the ages of 10 and 25 years and 41% of the population are below 15 years of age (Adolescent Sexual and Reproductive Health Implementation Strategy 2003:5). Approximately a third of the total population is classified as young and this makes young people an important section of the population (Rob 2008).

Kates and Leggoe (2005) state that Botswana has the second highest HIV/AIDS prevalence rate in the world. The adult HIV/AIDS prevalence is about 23.9%, second highest in the world after Swaziland (Rob 2008). The HIV/AIDS prevalence rate is also high and increasing among young people aged 15ï 19 years and 20ï 24 years and Botswana has some of the highest prevalence rates in the world especially for young women.

WHO (2005) report that the HIV prevalence in major urban areas of Botswana (Gaborone and Francistown) increased from 15% in 1992 to 45% in 2003 in Gaborone while in Francistown it increased from 24% in 1992 to 46% in 2003. The 15-19 and 20-24 age

groups exhibit high and increasing HIV infection trends as a result of unprotected sex hence the focus on young people aged 15-25 years in Francistown, Botswana in this study.

The government of Botswana is providing young people with HIV education and prevention messages to help protect them from infection through the Youth Health Organization (YOHO). YOHO is a non-government organization (NGO) that educates young people about HIV/AIDS using Botswana-specific HIV material developed for the students (Santis, Roseenblum, Whiteman and Bloome 2007:26). Fredriksson-Bass and Kanabus (2008) report that the education of young people includes the ñABCò strategy of HIV/AIDS prevention. Safe sex billboards and posters are seen everywhere in Botswana. The condoms are distributed freely and the use of condoms is part of youth education program.

Afrol news (2008:1) reports that in spite of all the awareness campaigns which provide knowledge about HIV/AIDS prevention as well as free distribution of condom to young people in Botswana, the rate of infection is still high among them. Even when condoms are widely available and affordable, adolescents seem reluctant to obtain and use them. According to Lehrer (2002:1) experts are not completely sure why the prevalence rate is increasing in young people. Nonetheless some think that the cause could be that many young people do not take HIV/AIDS seriously. Most teenagers have heard about HIV/AIDS prevention in schools, on television and from friends and family to an extent that they express that they are getting tired hearing about HIV/AIDS prevention. To many teenagers, HIV/AIDS does not seem to be a big deal anymore and with all the new medication available, people with AIDS live longer. However, the new infections are increasing everyday among young people, especially young females (Lehrer 2002:1).

1.2.1 Statement of the research problem

Afrol news (2008:1) reports that, according to Joint United Nations Programme on HIV/AIDS (UNAIDS) the AIDS epidemic in Botswana shows no signs of levelling off. The prevalence of HIV/AIDS among young people between the ages 15-24 years is

15.3% of young women and 5.1% of young men living with HIV (Melles 2009). The rate of teenage pregnancy is also high in Botswana and the HIV prevalence among young pregnant women aged 15-24 years remains at 39%, suggesting that young people engage in unprotected sexual intercourse, which is the dominant mode of HIV transmission in Africa.

In spite of all the awareness campaigns which provide information about HIV/AIDS prevention as well as free distribution of condom to young people in Botswana, the infection rate among them is still high. Seboni (2001:3) cites the WHO/University of Botswana KAP study (2000) which indicated that there is high knowledge (HIV awareness of 95%) about HIV and other risky behaviours such as early initiation of sexual intercourse among adolescents in Botswana. However, this knowledge has been found to be incongruent with the actual practice of safe sex as evidenced by high infection rates of HIV/AIDS among young people in Botswana.

According to Aral and Douglas (2007:40) knowledge alone is not always enough to curb the spread of sexually transmitted infections (STIs). Awareness of health behaviour does not necessarily translate into engaging in it. The same authors argue that behaviour change would be an effective strategy in curbing the spread of HIV/AIDS. It is the researcherôs belief that positive attitude influences behaviour positively. The study therefore focuses on the attitude of young people towards the ñABCò strategy of HIV/AIDS prevention.

1.3 PURPOSE OF THE RESEARCH

The purpose of this study is to determine the attitudes of young people aged 15ï 25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana.

1.4 RESEARCH OBJECTIVES

The objectives of the study are to:

- Describe the attitude of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana.

- Establish if the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana differ for males and females.
- Establish if the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana differ for age groups 15-19 and 20-25 years
- Make recommendations regarding the strategies that can be used to foster positive attitudes in young people aged 15-25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana.

1.5 RESEARCH QUESTIONS

The study attempts to answer the following questions:

- What is the attitude of young people aged 15-25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana?
- Do attitudes of young (15-25 years) people towards the ñABCòstrategy for the prevention of HIV/AIDS in Francistown, Botswana differ for males and females?
- Do attitudes of young (15-25 years) males and females towards the ñABCò strategy for the prevention of HIV/AIDS in Francistown, Botswana differ for age groups 15-19 years and 20-25 years?

1.6 SIGNIFICANCE OF THE STUDY

The findings from this study will provide insight into the attitudes of young people aged 15-25 years towards ñABCòstrategy so that future education programs on prevention of HIV/AIDS focus not only on information giving but also on changing attitudes, if necessary.

1.7 DEFINITION OF TERMS

ABC strategy: According to Kanabus and Noble (2007) Presidential Emergency Plan For AIDS Relief (PEPFAR) definition of ñABCòstrategy is,

Abstinence for youth; non-involvement in or/and, the delay of sexual debut until marriage. **B**eing tested for HIV and **b**eing faithful in marriage and monogamous relationships.
Correct and consistent use of condoms for those who practice high risk behaviour (e.g. prostitutes, sexually active discordant couples in which one partner is known to have HIV, substance abusers and others).

ABC strategy: According to Kanabus and Noble (2007) UNAIDS definition of ñABCò strategy is,
Abstinence or delaying first sex.
Being safer by **b**eing faithful to one partner or by reducing the number of sexual partners. **C**orrect and **c**onsistent use of **c**ondoms for sexually active young people, couples in which one partner is HIV positive, sex workers and their clients and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure.

For the purpose of this study ñABCòwill mean:
Abstinence: complete avoidance of sexual contact.
Being faithful: having only one sex partner in marital and monogamous relationships.
Condomise: correct and consistent use of condom.

AIDS*:* AIDS is an infectious disease caused by the human immuno virus (HIV). The virus affects and destroys the immune system and the people become more prone to opportunistic infections and other conditions (Lindsey 2001:4). The same definition applies in this study.

HIV: HIV is the virus that causes AIDS (Wikipedia 2008).

Attitude*:* Attitudes are the established ways of responding to people and situations that have been learnt, based on the beliefs, values and assumptions (Kotelnikov 2008).
For the purpose of this study, an attitude is a mental state involving beliefs regarding the óABCô strategy, feelings and values about óABCôand dispositions to practice the strategy.

Positive attitude: Having a positive attitude means to keep a set of ideas, values and thoughts that tend to look for the good, to advance, to overcome problems, to find the opportunities in every situation. It also means to have courage to act out those ideas and values (Wikipedia 2009). For the purpose of this study, positive attitude means keeping a set of ideas, values, thoughts that tend to look for the good in ñABCò and that advance the practice of ñABCò strategy in the prevention of HIV/AIDS.

Negative attitude: According to (Wikipedia 2009) negative attitude is all about feeling depressed, low insecure, indecisive. Exploring further, it is about living but not enjoying, complaining about things as they are happening, and not accepting things. For the purpose of this study, negative attitude means keepings a set of ideas, values, beliefs and thoughts that tend to promote non-acceptance and resistance towards the practice of ñABCò resulting in refusal to practice ñABCò consistently.

Prevention*:* According to Longman Dictionary of contemporary English (1992:819) prevention is stopping (something) happening or stop (someone) doing something. For the purpose of this study prevention (primary, secondary) in the context of HIV/AIDS, refers to activities designed to reduce the risk of becoming infected with HIV/AIDS (primary prevention) and the risk of transmitting the disease to others (secondary prevention).

Young people: Youth or young people are those persons between the ages of 15 and 24 years (Wikipedia 2009) but for the purpose of this study the term young people will be people between the ages 15ï 25 years and young people will be used interchangeably with youths.

1.8 THEORETICAL FRAMEWORK OF THE STUDY

The theoretical framework of this study is the Health Belief Model (HBM). Campus (2005) defines HBM as a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. According to Dennill, King, Lock and Swanepoel (1999:156) HBM was developed to provide a

framework to explain why some people take specific actions to avoid illness while others fail to protect themselves. Stanhope and Lancaster (2000:252) state that the HBM is beneficial in assessing health protection or disease prevention behaviours. It is also useful in organising information about clientsô views on the state of health and what factors may influence them to change their behaviour. The HBM, when used appropriately provides organised assessment data about clientsô abilities and motivation to change their health status and health education programs to address clientôs needs.

The HBM postulates that health seeking behaviour is influenced by a personôs perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat (Polit and Hungler 1999:128).

Aral and Douglas (2007:144) state that, in terms of social marketing, the HBM suggests that ñconsumersò are more likely to adopt a new behaviour as recommended in a campaign if:

- Individual feels threatened by the disease
- If they perceive that the benefits outweigh the barriers that are present

In terms of costs and benefits; this refers to how an individual assesses the advantages and disadvantages of a particular, recommended course of action.

1.8.1 Assumptions of Health Belief Model

According to Campus (2005) 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 is aware of the problem or issue with all details related to it. It is only when one realises this that one would be able to move a step further into action.

Again the HBM also assumes that a person will take action if that person has a positive expectation that by taking a recommended action, he or she will avoid a negative health condition. The person needs to see the benefits that he or she will get from practising a

recommended behaviour. If a person fails to see any benefit, it would be difficult for him or her to take the necessary action(s) or to continue doing so.

Further assumption of the HBM is that a person takes a health related action if the person believes that he or she can successfully take the recommended action. It requires the person to feel confident that he or she has the capacity to take the recommended action and this means that there is a need to ensure that the person has the necessary knowledge and skills in a supportive environment to carry out the required action.

The relevance of this model to the study is its description of the effects that individual beliefs/perceptions and motivating environmental factors have on behavioural change.

1.8.2 Components of Health Belief Model

According to ReCAPP (2005) the concepts of HBM include

- perceived susceptibility
- perceived severity
- perceived benefits,
- perceived barriers
- cues to action
- self efficacy

HBM is constituted by four constructs representing the perceived threat and net benefits: perceived *susceptibility,* perceived *severity,* perceived *benefits,* and perceived *barriers.* These concepts were proposed as accounting for peopleôs ñreadiness to act.ò An added concept, *cues to action,* would activate that readiness and stimulate behaviour. A recent addition to the HBM is the concept of *self-efficacy,* or oneôs confidence in the ability to successfully perform an action (Campus 2005).

1.8.2.1 Perceived susceptibility

Perceived susceptibility refers one's perceived chances of getting a disease when one is aware of the problem or issues with all the details related to it. A person's perception that a health problem is personally relevant will influence him/her to take action about a disease threat. One requires an understanding on how any health problem or issue will affect oneself to acknowledge the risk of being affected by the problem. This requires that there should be activities that increase the individual's perception of his or her own vulnerability to a condition (ReCAPP 2005). Someone who does not see himself or herself being at risk will not change a health related attitude or practice (Fan, Conner and Villarreal 2004:141).

Boskey (2007) maintains that those who do not think that they are at risk of acquiring HIV from unprotected sex are unlikely to use condom.

1.8.2.2 Perceived severity

ReCAPP (2005) refers perceived severity as one's own opinion about how serious a condition is and what its consequences are. When one recognizes one's susceptibility to a certain problem or condition, it does not necessarily motivate one to take the necessary action(s) unless one realizes that getting the condition would have serious physical, psychological and social implications. It is when one realizes the magnitude of the negative consequences of a condition, that one could take the necessary action(s) to avoid these negative consequences.

1.8.2.3 Perceived benefits

According to ReCAPP (2005) perceived benefits means one's belief in the efficacy of the advised action to reduce the risk of a disease or seriousness of its impact. The person needs to believe that by taking a certain action, it will help him or her to avoid or prevent a problem from occurring. It is the belief that gives a person confidence to take the action because of the expected outcomes. Boskey (2007) states that it is difficult to convince people to change behaviour if there is nothing in it for them.

1.8.2.4 Perceived barriers

Perceived barriers are the potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands (ReCAPP 2005). According to Polit and Hungler (1999:128) perceived barriers refer to hindrances to engage in preventive behaviours including such factors as inconvenience and unpleasantness. The barriers that can affect peopleôs decision making to take a particular action include costs, duration, complexity of the desired behaviour and accessibility to services that would support taking and maintaining the required action(s).

Boskey (2007) argues that one of the major reasons people do not change their health behaviours is that they think that doing so is going to be hard, sometimes it is not just a matter of physical difficulty but social difficulty as well and that changing health behaviours can cost effort, money and time.

1.8.2.5 Cues to action

According to ReCAPP (2005) cues to action are strategies required to activate readiness. A cue to action is something that helps move someone from wanting to make a health change to actually making the change (Boskey 2007). It motivates on the part of the person to have the desire to comply with a prescribed action of treatment, to have concern about health matters, to be willing to seek and accept health care and to engage in positive health activities (Polit and Hungler 1999:129). Examples of cues to action are mass media campaigns, information from health professionals, illness or death of a family member or friend from the negative health condition, which in the study will be HIV/AIDS.

1.8.2.6 Self efficacy

ReCAPP (2005) defines self efficacy as confidence in onesô ability to take action to a specific health problem. One should feel that he/she is capable of taking the necessary action correctly because it is that confidence that would motivate him/her to initiate and sustain the action.

1.8.3 Application of the model

Application of HBM in this study on young peoplesô motivation to practice óABCô strategy in order to promote health and prevent HIV/AIDS will be based on the following:

- How strongly young people believe that they are susceptible to HIV/AIDS
- The belief that HIV/AIDS would have serious effects on their lives and its associated consequences. The young peopleôs perceptions that the consequences of getting HIV are significant enough to try to avoid it and practice ñABCò strategy for preventing HIV/AIDS
- The perceived benefits of a positive attitude towards ñABCò strategy in the prevention of HIV/AIDS
- The perceived barriers they must overcome in order to maintain a positive attitude towards ñABCò strategy and to practice aspects of the strategy being faithful to one sex partner and/or to use a condom
- Cues to action/strategies that would motivate them to adopt a positive attitude towards ñABCò strategy necessary for the prevention of HIV/AIDS. These include exposure to mass media campaigns, health education
- The confidence in their ability to practice ñABCò strategy in the prevention of HIV/AIDS

Figure 1.1 below shows the structural components of the Health Belief Model.

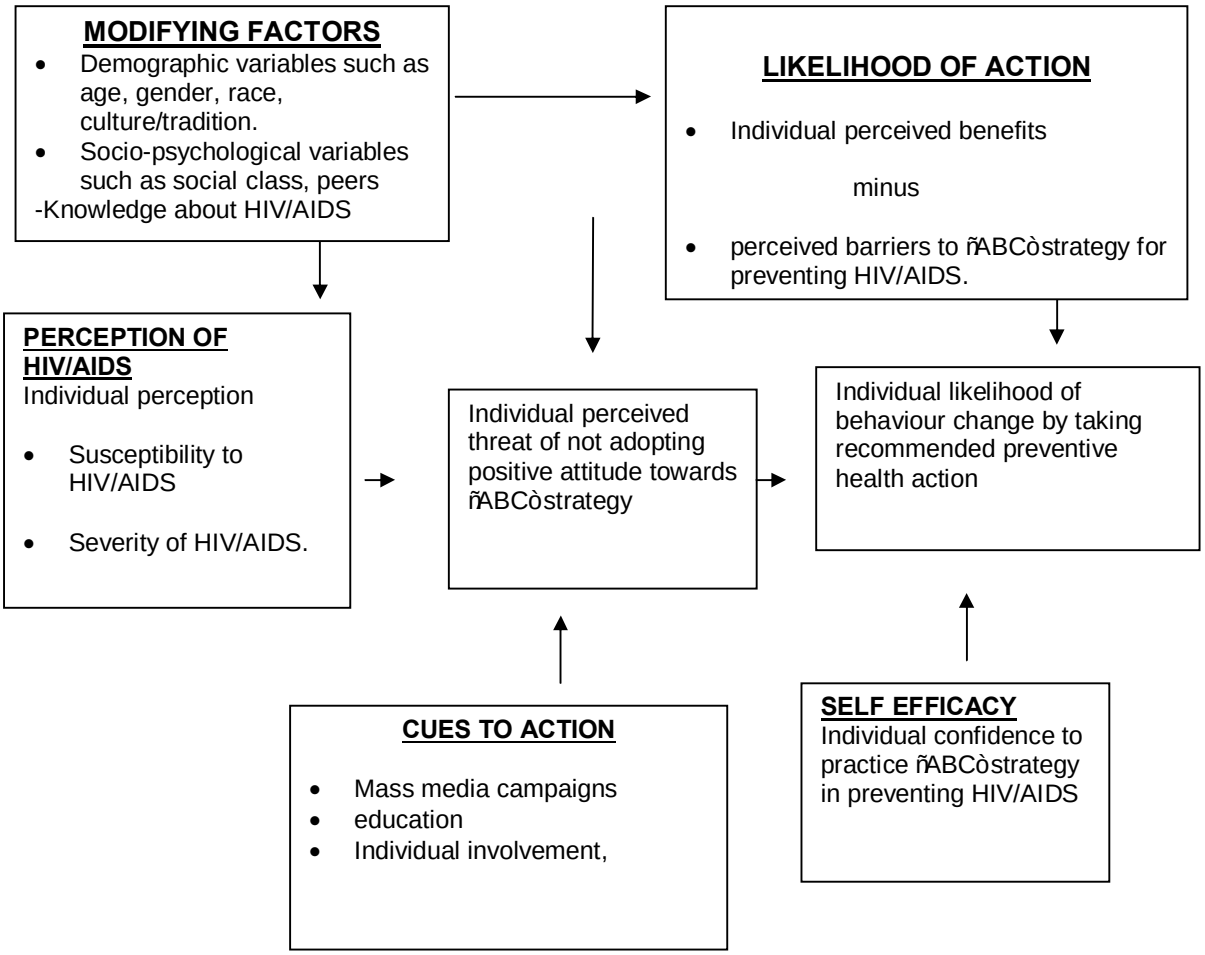

Figure 1.1 ADAPTED HEALTH BELIEF MODEL (Adapted from Becker 1974 Source: Naidoo and Willis (2003:222)

1.9 RESEARCH DESIGN AND METHOD

A quantitative, non experimental, descriptive and comparative study was used for the purpose of this study. The use of non experimental research ensured that social processes occurring in natural social settings were observed which might not be the case with experimental research (Babbie 2001:235). It was used because the

researcher collected data without introducing any treatment or changes to the subjects (the young people).

The purpose of the descriptive design was to provide the opportunity to identify the variable within the phenomenon of interest (Burns and Grove 1999:251), namely young peopleôs attitude towards the ñABCò strategy of HIV/AIDS prevention. The research aimed to describe the attitude of young people aged 15 -25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana in order to gain insight into the reasons for the increasing prevalence of HIV/AIDS among young people in spite of the high level of knowledge regarding HIV/AIDS they have.

Lauer (2006:26) posits that the purpose of comparative descriptive study is to compare the characteristics of two or more groups of participants. The researcher compared the attitudes of young people (20-25 years) towards ñABCò strategy of HIV/AIDS prevention by gender (male and female) and by age groups (15-19 and 20-25 years).

1.9.1 Population

A population is the entire aggregation of cases that meet a specified set of criteria. Target population is the population which the researcher is interested in and accessible population comprises of cases from the target population that are accessible to the researcher as a pool of subjects (Polit, Hungler and Beck 2001:233).

The study population comprised of male and female young people in Francistown, Botswana. The target population consisted of young people between the ages of 15 and 25 years and the accessible population comprised of young people aged 15-25 years in secondary schools, institutions of higher learning and at workplaces in Francistown, Botswana.

1.9.2 Sample and Sampling techniques

The sampling approach that was used was the probability sampling which is defined by Polit et al (2001:254) as a design that involves the random selection of elements from

the population. Probability sampling was used to ensure that each element in the population had a chance of being selected and that the sample would to be representative of the population from which it had been selected. It was also used to ensure that the findings of the study would be generalized to the target population.

The stratified random sampling method was selected in order to achieve representation. The population was divided into strata based on gender and age groups of 15 -19 years and 20 - 25 years. This was in line with the research questions.

The researcher obtained the list of all secondary schools and institutions of learning from Ministry of Education in Francistown. From the list of nine (9) secondary schools, the researcher randomly selected two secondary schools. One institution of learning was randomly selected from the six institutions of learning.

Young people aged 15-25 years were randomly selected from the secondary schools, institutions of higher learning and work place. The detailed procedure used for the selection of sample is discussed in chapter 3 of this study.

1.9.3 Data collection instrument

According to Polit and Hungler (1999:24) quantitative research uses structured procedures and formal instruments to collect good quality data. The researcher used a self-developed, structured questionnaire to collect data from the respondents. The questionnaire consisted of sections that elicited information regarding the attitude of young people aged 15-25 years regarding the ñABCò strategy of HIV/AIDS prevention in Francistown, Botswana. The questionnaire was designed in consultation with a statistical consultant who critically reviewed and verified the interpretations of the questions in the questionnaire. Feedback from the statistician was used to improve the questionnaire. Details of the research instrument are discussed in chapter 3 of this study.

1.9.3.1 Measures to ensure validity and reliability

Validity refers to whether an instrument actually measures that which it is supposed to measure, given the context in which it is applied (Brink 1999:167) whilst reliability is defined as the degree to which the instrument can be dependent upon to yield consistent results (Brink 1999:171). Face and content validity, pre-testing of the questionnaire, test-retest reliability as discussed fully in chapter 3 of this study ensured that the instrument was tested for both validity and reliability.

1.9.4 Data collection

The researcher used a self-developed, structured, self-administered questionnaire to collect data from the respondents.

1.9.5 Data analysis

Data were analysed using a computer data analysis program, the Statistical Package for the Social Sciences (SPSS) version 13.0. This approach was chosen because the study was aiming at quantifying the attitudes of young people aged 15-25 years towards "ABCòstrategy in the prevention of HIV/AIDS. Data were presented in tables and figures using a descriptive and inferential statistics. Data were analysed with the assistance of a statistician.

1.10 ETHICAL CONSIDERATIONS

As the study pertained to secondary school going young people and university students between the ages 15-25 years in Francistown, Botswana, permission to conduct the study was obtained from the Ministry of Education, Ministry of Health and authorities of the selected schools. Permission was also sought from the authorities of the selected work place (Annexure C,D,E,F,G,H and I).

The purpose of the study was explained to the respondents in the letter that accompanied the questionnaire. Anonymity and confidentiality were assured to ensure that the identity of the respondents could not be linked with their individual responses (Burns and Grove 2001:207). The respondents between the ages 21-25 signed an

informed consent form and those below 21 years were only allowed to participate once the parents or legal guardians had signed a consent form. Ethical issues pertinent to this study are discussed in chapter 3 of this study.

1.11 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted among young people aged 15-25 years in Francistown, Botswana. Given the fact that the stratified sample was randomly selected, the results would be generalised to secondary school, university and working young people in Francistown that fall within the age range of 15-25 years. The research aimed to describe the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown in Botswana. The findings from this study would provide insight into the attitudes of young people aged 15ï 25 years towards ñABCò strategy so that future education programs on prevention of HIV/AIDS focus not only on information giving but also on changing attitudes.

There are young people who were not accessible to the researcher because they are not in schools. The results may therefore not be representative of the attitudes all of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown in Botswana. Because the study was done in Francistown only, the results would also not be representative of the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in other cities or towns in Botswana.

1.12 STRUCTURE OF THE DISSERTATION

The layout of the study report will be divided into five chapters as follows:

Chapter 1

The chapter contains the introduction, background information and the statement of the research problem, significance of the study, the purpose, research objectives and definitions of key concepts that have been used in the study. The research design and methods, validity, reliability and ethical considerations are also included in this chapter.

Chapter 2

The chapter contains relevant literature review from global, regional and local perspectives on concepts pertaining to this study which was guided by a conceptual framework.

Chapter 3

The chapter contains the methodology used in this research and it includes the design, population, sample and sampling techniques, methods of data collection and analysis as well as measures used to ensure validity and reliability.

Chapter 4

The chapter outlines the research findings from data analysis presented in tables, figures and graphs. The narrative form will also be used.

Chapter 5

Summary, conclusions and recommendations are presented as well as some of the limitations of the study and the bibliography.

1.13 CONCLUSION

This chapter gave an orientation to the study. The purpose of the study, research questions and objectives were explained. Relevant concepts were defined, and an outline of the study was provided. In chapter 2, a review of the relevant literature was presented.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this chapter is to introduce the literature reviewed on the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS. A literature review involves the systematic identification, location, scrutiny and summary of written material that contains information in a specific research problem (Polit and Hungler 1999:645). Polit et al (2001:20) state that the overall purpose of a research literature review is to assemble knowledge on a topic regarding what is known or what has been studied about the area and where knowledge gaps exist. A thorough literature review provides a foundation on which to base new knowledge (Polit et al 2001:40).

2.2 SCOPE OF THE LITERATURE REVIEW

In this study, the literature review was guided by the research problem, research questions and the theoretical framework. The researcher looked at various reports and studies conducted all over the world including the country of study Botswana. The focus was on the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana.

2.3 REVIEW OF LITERATURE

The literature review is presented according to the key concepts as follows:

- HIV/AIDS
- Attitude of young people aged 15-25 years regarding the ABC strategy of HIV/AIDS prevention
- Health Belief Model

2.3.1 HIV/AIDS

Fredriksson-Bass and Kanabus (2008) observe that AIDS epidemic has had a profound impact in sub-Saharan Africa. According to Joint United Nations Programme on HIV/AIDS (UNAIDS) (2005), sub-Saharan Africa has the majority of people living with HIV/AIDS (64%), new HIV infections (65%), and AIDS-related deaths (77%). The average life expectancy in sub-Saharan Africa is now 47 years when it could have been be 62 without AIDS (Fredriksson-Bass and Kanabus 2008). In Botswana, the life expectancy at birth fell from 65 years in 1990-1995 to less than 40 years in 2000-2005 as a result of HIV/AIDS (United Nations 2004).

Women make up the majority of those estimated to be living with HIV/AIDS in the region and young people are at particular risk (Berry 2008; UNAIDS 2005). Sixty two (62%) of the worldôs young people living with HIV/AIDS are in sub-Saharan Africa and they are between the ages 15-24 (Kaiser Family Foundation 2004). The impact on young people is exacerbated by the fact that the population of sub-Saharan Africa is quite young relative to other regions in the world, with 44% of the population below the age of 15 compared to 29% globally (World Population Data Sheet 2005). Like other sub-Saharan countries, Botswana has high HIV/AIDS prevalence among young people aged 15-24 years and women (Melles 2009).

2.3.2 Knowledge of young people about HIV/AIDS

Research has shown that where young people are knowledgeable about HIV/AIDS risks and prevention strategies, they change their behaviour in ways that reduces their vulnerability (Douthwaite and Sareoun 2006:510; Wodi 2005:89). For example, in several countries, targeted education has led to delayed sexual debut and increased use of condoms resulting in a decrease in HIV prevalence in young people. In Zambia, the knowledge about risks of pregnancy and HIV/AIDS resulted in a decline in HIV/AIDS prevalence among young people aged 15 -19 years from 28% in 1993 to 15% in 1998. The decline was attributed to the delayed sexual initiation, reduced number of sexual partners and increased condom use (Magnani, Karim, Weiss, Bond, Lemba and Morgan 2002:80; UNICEF 2007).

Young Nigerian students who were given health education and a demonstration on the correct use of condoms showed an increase in condom use, a reduction in the mean number of sexual partners and increased HIV/AIDS knowledge (Fawole, Asuzu, Oduntan and Brieger 1999:679; Wodi 2005:89 and Kaiser report 2006).

In a study on the adolescentsô knowledge of ñABCò strategy in Kenya, half of the respondents demonstrated adequate knowledge of the meaning of abstinence and why it was important as an HIV prevention method. The knowledge regarding ôbeing faithful ôand condom use was found to be inadequate (Kaiser Report 2006). Another study on sexual abstinence behaviour among youth by Koffi and Kawahara (2008:1486) revealed that females were more knowledgeable about ôbeing faithfulô than males.

Despite high levels of knowledge of HIV/AIDS among young people, previous studies have demonstrated a gap between knowledge and reported sexual behaviours (James, Reddy, Taylor and Jinabhai, 2004: 267; Lema, Katapa and Musa 2008:80; Seboni 2001:3; Thembi 2000:9).

Reports on sexual and reproductive health of young people in Botswana showed that most young people have been exposed to information about many aspects of sexual and reproductive health and yet the young people aged 15-19 and 20-24 years in Botswana still exhibit high HIV infection rates and that the principal mode of transmission of HIV is through heterosexual contact (WHO 2005).

Studies on the HIV/AIDS related knowledge of young people in Botswana revealed high levels of knowledge. In a study on predictors of knowledge about HIV/AIDS among adolescents, it was found that most young people (63.1%) displayed adequate knowledge about HIV/AIDS (Fako, Kangara and Forcheh 2010:116). Seboni (2001:3) cites the WHO/ University of Botswana KAP study (2000) which states that there is high knowledge (HIV awareness of 95%) about HIV and other risky behaviours such as early initiation of sexual intercourse among adolescents in Botswana. However this knowledge has been found to be incongruent with the actual practice of safe sex

hence the high infection rates of HIV/AIDS among young people in Botswana.

Aral and Douglas (2007:40) argue that knowledge alone about risky behaviour and HIV/AIDS transmission is not always enough because it does not necessarily translate into safe sexual behaviour. The same authors maintain that attitude and behaviour change are effective in curbing the spread of STI and HIV/AIDS. The goal of changing behaviours is to ultimately decrease the rate of disease transmission by means of correct and consistent condom use, delaying the initiation of sexual activity, mutual monogamy and decreasing the numbers of sexual partners.

2.3.3 Attitude of young people towards "ABC" strategy for prevention

Centres for Disease Control (CDC) factsheets [Sa:1] quoted in CDC's youth research behavioural survey which indicated that many young people begin having sexual intercourse at early ages. Forty seven (47%) of high school students are reported to have had sexual intercourse and 7.4% of them reported first sexual intercourse before age 13 in America. The reported age at first encounter was found to be lower in boys (16.8 years) than in girls (18.3 years) among secondary school students in Rwanda (Rahlenbeck & Uhagaze 2004:117).

Odu, Asekun-Olarinmoye, Bamidele, Egbewale, Amusan and Olowu (2008:93) conducted a study on attitudes of young people towards HIV/AIDS in a tertiary institution in South-Western, Nigeria. The findings showed that the majority of respondents had their first sexual experience between the ages of 15 and 19 years. The results also revealed that 79% of the sexually active respondents stated that they occasionally or never used condoms with persons they believed they could trust such as spouses, fiancées and mutually faithful partners.

The study by Douthwaite and Sareoun (2006:510) on the sexual behaviours of young men found that half of the respondents had multiple sex partners and 71% used a condom at last sexual intercourse. Furthermore the study revealed that condom use was higher among those that were positive and informed about condoms.
In another study by Rahlenbeck and Uhagaze (2004:117) on sexual behaviour of

secondary school adolescents in Rwanda, having more than one sex partner was reported by 9%, the majority of whom claimed regular use of a condom with multiple partners.

A study was conducted on attitudes of Lesotho polytechnic students towards ABC strategy by Morolong (2004:48). According to the findings of the study, less than half (41.8%) of the respondents aged 20 - 25 years choose abstinence as the best means of protection. Only 28% indicated they would use condom when having sex and 25% chose abstinence, being faithful to oneôs partner and using condom if one indulges in sex. The study showed that the students were aware of the need for protection against infections but their attitude towards using condoms and being faithful to one partner was negative (Morolong 2004:68).

Research has shown that a large proportion of young people are not concerned about becoming infected with HIV (UNICEF 2001). The attitude of many Botswana youth is that HIV is not real and they do not believe that HIV is a threat to them. Over the years, a lot of debates within civil society and in certain government sectors in Botswana have focused on adolescent sexual activities. One of the key concerns has been the high rate of teenage pregnancy. Data from the United Nations Development Programme rated teenage pregnancy in Botswana at 19%. Studies conducted on sexual behaviour among adolescents point to the high rates at which young persons are engaging in unsafe sexual activities (Francoeur 2004:90). The implication is that young people engage in unprotected sex hence the increase in HIV/AIDS infections (Francoeur 2004:90).

Sabone, Ntsayagae, Brown, Seboni, Mogobe and Sebego (2007:334) studied the perceptions of undergraduate students not participating in HIV/AIDS prevention activities in Botswana. The findings showed that the students felt that abstinence could be a good way of preventing the spread of HIV/AIDS but they believed that it was not practical for them. Again the students reported that while being faithful to oneôs partner made sense, it was also not practical in a campus environment because of factors that included peer pressure and boredom. In the same study the students also indicated condom use rate was low among them as the decision making related to sex was

male dominated and that a female student would not even find out if the partner was using a condom or not. Another finding was that female students date older men from outside the university because of money so they exchange unprotected sex for money.

Card, Amarillas, Conner, Akers, Solomon and Diclemente (2007:13) note that the ñABCò strategy is sometimes hard to implement because when one person insists on safe sex, the other partner may feel that he or she is not trusted. Similarly one person may not insist on safer sex out of fear of offending his or her partner. Partners may equate a request for safe sex as a sign of unfaithfulness and may react by withdrawing financial support or terminating the relationship. Women in particular may find it difficult to negotiate safer sex since women often have less power and control in their relationship.

In Zambia, HIV prevalence among young people aged 15-19 years declined from 28% in 1993 to15% in 1998. The decline in prevalence among young people in Lusaka, Zambia was attributed to the delayed sexual initiation (abstain), reduced number of sexual partners (be faithful), increased condom use as well as positive beliefs or attitudes about condom use (UNICEF 2007).

2.3.3.1 Attitude of young people towards abstinence

Research has shown that in sub-Saharan African countries (hardest hit by HIV/AIDS) sexual activity begins early and before marriage. According to surveys, on average, more than 40% of female young people in sub- Saharan Africa have had premarital sex before the age of 20 and among young men sex before marriage is even more common (Odu et al 2008: 9; Rahlenbeck & Uhagaze 2004:117).

Many studies report that, although young people agree that abstinence is the most effective and only certain way to avoid HIV transmission, they find it difficult to practice it (Koffi and Kawahara 2008: 486; Morolong 2004:68 ; Sabone et al 2007:334).

Morrison-Beedy, Carey, Côté-Arsenault, Seibold-Simpson and Robinson (2008:185) conducted a study among African American adolescent girls on why they remained abstinent despite being in sexually active social climates. The results revealed that they focused on self respect (*I'm worth it)*, impact of mothers (*mama says think before you let g*o), influence of boys and other peers (*boys will be boys*) and potential negative consequences of sex (*hold on, there's a catch*).

According to a study by Lillie, Pulerwits and Curbow (2009:281) on abstinence among the school going youth, the findings revealed that the majority (81%) of Kenyan youth indicated that they would wait until the right time to have sex. Another similar study by Kurtz, Douglas and Lugo (2005:41, the majority of Anguillan youths indicated that they would like to wait until they are older before having sex. In both studies, there were more females than males who indicated that they were ready to wait and avoid sex while in a relationship.

2.3.3.2 Attitude of young people towards being faithful to one sexual partner

Fidelity or faithfulness is commonly associated with married or cohabiting couples. Thus the youths might view it as a distant option, when it comes to HIV prevention, because they are still searching for the right partners. However, there are other factors which might prevent the youths from practising faithfulness such as socio-economic status and cultural norms. It was reported that the female youths in Zambia had multiple sexual partners to escape poverty, whilst male youths engaged in multiple sexual relationships to prove their masculinity. The female youths felt unable to change their own behaviours to practice fidelity due to the economic ties around multiple sexual partnerships (Masimba 2008). Some youths might also be influenced into having multiple partners by promiscuous role models who portray casual sex as being glamorous, such as those appearing on television programmes (Jackson 2002:123).

A study by Guiella and Madise (2008:189) provided understanding of patterns of adolescentôs sexual behaviour and the factors that affect condom use. The findings showed that few (11%) males aged 15-25 years had had sexual intercourse in last twelve months with more than two partners without a condoms. The reason given for

having multiple sex partners is that it is boring for some young people to have the same partner for a long time. Odu et al (2008:93) conducted a study on attitudes of young people to HIV/AIDS in a tertiary institution in South-Western, Nigeria. In the study 51.8% reported having one partner and 48.2% had multiple sexual partners. Another study by Boileau, Zunzunegui and Rashed (2009:1016) on gender differences in unsafe sexual behaviour among young people in urban Mali found out that the prevalence of having more than one partner in the last six months was significantly higher for men than for women (64% versus 32%).

Male and female young people in the study by James et al (2004:266) revealed that 58.6% males to 62.1% females believed that they would communicate with their partners about HIV/AIDS and majority knew that being faithful is important in a relationship.

2.3.3.3 Attitude of young people towards the use of condoms

Studies that were conducted about a decade ago reported that young people were not using condoms because of lack of knowledge, lack of access to condoms and misconceptions about condoms. However many recent research reports increased levels of knowledge of condoms among young people (James et al 2004; Lema et al 2008:80; Seboni 2001:3 and Thembi 2009: 9). The knowledge of condoms among young people is a necessary condition for the acceptance and use of condoms, but beliefs about condoms, both positive and negative, also are likely to influence use of condoms.

In many studies, the attitudes of young people towards condoms were favourable because of the belief that condom helps to prevent HIV/AIDS and one can infected from a regular partner, (88.1% females and 82.0% males) believed that condom worths preventing HIV/AIDS (Koffi and Kawahara 2008:1486; James et al 2004:266). However, some young people expressed negative views which are likely to influence their use. The negative views about condoms expressed by young people in many studies are that condoms are difficult to use, they reduce sexual pleasure and they are used only for illicit sex and prostitution and not in steady relationships. Some believed that when a relationship moves from casual to serious, it is no longer necessary to use

condoms. Other views were that a woman loses a man's respect if she asks him to use a condom, and that using a condom is a sign of not trusting one's partner (Maharaj 2006:29; Manji, Pena and Durbrow 2007:990; Odu et al 2008:93; Prata, Vahldnia and Fraser 2005:195; James et al 2004:267). However, the study by Potsonen and Kontula (1999:214) on condom use found that the majority of males (96%) regarded using a condom easier than females (88%).

In Botswana, the majority of young people (56%) who participated in a study on attitudes towards condom use by Marandu and Chamme (2004:500) did not hold the view that condoms reduce sexual sensations. In all the studies on condom use stated above, it was found that condom use was higher in males than females and more males believed that condoms diminish pleasure.

A study by Meekers, Ahmed and Molatlhegi (2001:297) on constraints to adolescent condom procurement in Botswana showed that many young people perceived that access to condom is more difficult from public sector outlet than from private sector outlets because the public sector providers tend to question the adolescentsôbehaviour while the latter do not. A large proportion of young people in other studies indicated that buying condoms was embarrassing but males were significantly less likely than females to feel embarrassed about buying condoms (8% versus 19%) (Potsonen and Kontula 1999:211; Prata et al 2005:194).

In different studies on condom use, it has been indicated that condoms must be used constantly and correctly to provide maximum protection (UNAID 2005), which means that with each act of sexual encounter, a new condom should be used and that the condom must be applied correctly. Sixty eight percent adolescents in a study by Wodi (2005:93) would use condom always if they have sex with their partners. Patel, Gutnik, Yoskowitz, Osullivan and Kaufman (2006:920) studied patterns of reasoning and decision making about condom use by urban college students. The findings revealed consistent condom use (35.0%), inconsistent condom use (16.7%), shifting from consistent to inconsistent condom use (35.0%), and shifting from inconsistent to consistent condom use (13.3%).

The findings of the study by Bankole, Ahmed, Neema, Ouedraogo and Konyani (2008:210) on condom use among adolescents aged 15-24 years in Burkina Faso, Ghana, Malawi and Uganda indicated that the extent to which adolescents use condoms consistently varies across countries. The proportion reporting consistent use of the method in the 3 months preceding the survey is 38% in Burkina Faso, 47% in Ghana, 20% in Malawi and 36% in Uganda. In the same study, the age difference between partners was found to be the major determinant of consistent condom use. Other important predictors of consistent condom use were residence, education, living arrangement and exposure to mass media, specifically the radio and newspaper.

Many adolescents continue to have unprotected sex even after they know that they are HIV positive because they cannot figure out a way to tell their sexual partners, school mates or their family (Alcamo 2002:78). In a study by Marandu and Chamme (2004:500) on attitudes towards condom use for prevention of HIV infection in Botswana, only 14% of young people indicated that they would have sexual relation without using condom because it would be difficult for them to suggest condom to a person when in love. Another study by Tagoe and Aggor (2009:63) on knowledge, behaviour, perceptions and attitudes of university of Ghana students towards HIV/AIDS showed that the majority of respondents (62.8%) females indicated that they would have sexual relation without using condom with their partners because of the difficulty of discussing the status with their partner.

2.3.4 Literature related to Health Belief Model

In a study by Shigemi, Shinji, Masamine, Masao and Susumu (2007:69) on whether two subscales of the health belief model, perceived severity and perceived susceptibility are associated with abstinence intention among Nepalese male adolescent students aged 14-19 years for HIV/AIDS prevention shows that over 53% strongly agreed with abstinence intention. Students with higher levels of perceived severity strongly agreed with abstinence intention (crude odds ratio 1.86, 95% confidence interval (cl) 1.02-3.38; adjusted odds ratio 1.94, 95% cl 1.05-3.58) but those with higher levels of perceived susceptibility did not. Age stratified analysis showed that a high level of perceived susceptibility tended to decrease strong abstinence intention among students

aged 16-19 years. The researchers concluded that perceived severity enhanced abstinence intention.

2.4 CONCLUSION

Studies and reports on abstinence, condom and faithfulness among young people were reviewed. A number of studies reported that there was high knowledge about HIV and other risky behaviour such as early initiation of sexual intercourse among adolescents globally and in Botswana. However this knowledge has been found to be incongruent with the actual practice of safe sex in Botswana because of the high prevalence of HIV/AIDS among young people in Botswana. The health belief model guided the review of the studies which were classifed under different headings. Previous research has shown that intension is an important predictor of adopting one of the safe methods of prevention (ABC) but a gap exists between intensions and attitude. Many studies did not cover the ages from 15 to 25 years males and females. In the present study we explore the role of attitude with the differences within the ages and gender in the context of safe sex methods among young people.

Chapter 3 deals with the research methodology of the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

According to LoBiondo-Wood and Haber (2001:116) the methodology of a research project strongly influences the research process because it defines the method of carrying out the research and presenting the methods for data collection and measurement as well as the techniques used for data analysis. This chapter describes the research design, population, sample and sampling techniques, ethical considerations, data collection instrument and methods used in data gathering, as well as data analysis.

3.2 STUDY DESIGN

Polit and Hungler (1999:36) define the research design as an overall plan for obtaining answers to questions being studied and handling difficulties encountered during the research. The research design used for this study was non-experimental and quantitative in nature. Brink (1999:108) states that the purpose of non-experimental research is to describe phenomena and explore the relationship between variables and data can be collected without making any changes or introducing any treatment. It was suitable for this study because the researcher collected data without introducing any treatment or changes to the subjects (young people).

Quantitative research is a systematic process of obtaining formal objective data to describe the variables and their relationships. Quantitative research uses structured tools to generate numerical data and uses statistics to interpret, organise and represent the collected data (Burns and Grove 2001:30). The research used a structured questionnaire to collect data from the respondents. The approach allowed the researcher to ask all the respondents the same questions in the questionnaire which allowed objective data to be collected throughout the study.

The purpose of the descriptive design is to provide the opportunity to identify the variables within the phenomenon of interest (Burns and Grove 1999:251), in this study the attitudes of young people towards the ñABCò strategy of HIV/AIDS prevention. The focus of descriptive study is on the situation as it is, that is, conditions that exist, practices that prevail, beliefs, attitudes and ongoing processes (Babbie 2001:93). The researcher focussed on the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS. The researcher aimed to describe the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in order to gain insight into reasons for the increasing prevalence of HIV/AIDS among young people in spite of the high level of knowledge regarding the ñABCò strategy.

Lauer (2006:26) posits that the purpose of comparative descriptive study is to compare the characteristics of two or more groups of participants. Creswell (2002:328) states that a group comparison is when a researcher obtains scores of individuals or groups on the dependent variable and makes comparisons of their means and variance both within the group and between the groups. The researcher compared the attitudes of young people (15-19 years) to the attitudes of young adult (20-25 years) as well as the attitudes of males to those of females towards ñABCò strategy in the prevention of HIV/AIDS.

3.3 RESEARCH SETTING

Burns and Grove (2001:40) state that the research setting is the environment in which the research study takes place and can be a natural or controlled environment. Natural settings are real-life study environments without any changes made for the purpose of the study.

The study was conducted in Francistown which is the second largest city in Botswana, with a population of about 113,315 (census 2001) (Wikipedia 2008). It is located at the Northern region of Botswana (see Annexure A: map of Botswana). It is about 400 kilometres north-northeast from the capital Gaborone. According to Francoeur (2004:96) and WHO (2005:1) the HIV prevalence in Francistown increased from 23.7% in 1992 to 46% in 2003. The 15-19 and 20-24 age groups exhibit high and increasing

HIV infection trends as a result of unprotected sex hence the focus on young people aged 15-25 years in Francistown, Botswana in this study. The study was conducted in selected secondary schools, institution of higher learning and a place of work in Francistown where young people aged 15-25 years were mostly found. Table 3.1 below presents the number and names of secondary schools and institutions of higher learning in Francistown.

Table 3.1: Secondary schools and institutions of higher learning in Francistown

	Forms/Levels	Age ranges
Junior Secondary Schools 1. Donga JSS 2. Goldmine JSS 3. Mmei JSS 4. Montsamaisa JSS 5. Selepa JSS 6. Selolwe Hill JSS 7. Setlalekgosi JSS	Form 1 to 3	13 to16 years
Senior Secondary Schools 1. Francistown SSS 2. Mater Spei College	Form 4 to 5	16 to 20 years
Institutions of higher learning 1. University of Botswana (Francistown campus) 2. Institute of health sciences 3. Ba Isago University College 4. Francistown College of Education 5. NIIT training college 6. Gaborone institute of Professional Studies (Francistown campus) (GIPS)	Year 1 to 4	18 years and above

LEGEND

SSS: Senior secondary school

JSS: Junior secondary school

IHL: Institution of higher learning

3.4. RESEARCH METHODS

Research methods include the steps, procedures and strategies for gathering and analysing the data in a research investigation (Polit and Hungler 1999:709).

3.4.1 Population

According to Silva and Menezes (2001:32) population is the total number of individuals who have the same characteristics defined for a specific study. The population comprised of male and female young people in Francistown while the target population was young people (male and female) between the ages of 15-25 years. The accessible population comprised of all young people, male and female between the ages of 15-25 years in randomly selected schools and workplace in Francistown.

3.4.2. Sample and sampling techniques

A sample is a set of elements taken from a larger population according to certain rules (Johnson and Christensen 2004:199). Creswell (2002:163) defines a sample as a subgroup of the target population that the researcher plans to study for the purpose of making generalisations about the target population. The sample in this study comprised of young people, male and female between the ages of 15-25 years in one senior secondary school, one junior secondary school, one institute of higher education and a work place in Francistown district.

Inclusion criteria are the characteristics that the respondents must have in order to be included in the study (Burns and Grove 2001:367). The respondents had to meet the following criteria:

- Male and female young people between the ages 15-25 years enrolled in secondary schools, tertiary institution and work place selected for the study in Francistown, Botswana
- Residents of Francistown at the time when the study is conducted.

Exclusion criteria are the characteristics that the respondents lack in order not to be included in the study (Burns and Grove 2001:367). There were no exclusion

criteria for this study.

Henning (2004:72) maintains that sampling is a vital step in any research as it forms part of delineating the inquiry. A sampling method is a strategy used to obtain a sample. The method can either be probability or nonï probability sampling (Burns and Grove 1999:479). Probability sampling approach was used for the study. In probability sampling approach, each unit in the population has a chance of being selected and the sample can be said to be representative of the population from which it has been selected and as such generalisations of finding can be made to the population (Burns and Grove 1999:479). A stratified random sampling method was selected in order to achieve representation. The population was divided into strata based on gender and age groups of 15-19 years 20-25 years.

Creswell (2002:165) states that simple random sampling means that the researcher selects participants (or units, such as schools) for the sample so that any sample of size (N) has an equal probability of being selected from the population and the intent of simple random sampling is to choose units to be sampled that will be representative of the population.

A list of all secondary schools and a list of institutions of higher learning as shown in Table 3.1 in Francistown were obtained from Ministry of Education. From the list of secondary schools, one junior secondary school and one senior secondary school were randomly selected by writing down the school names and putting them in two boxes. One box was for junior secondary schools and the other was for senior secondary schools. The researcher picked a written down school name out of each container. One institution of higher learning was randomly selected from the list of institutions of higher learning as well using the same procedure. The schools that were selected are listed below in Table 3.2.

Table 3.2: Selected secondary schools and institution of higher learning in Francistown

	Forms	**Total number of learners**	**Age ranges**
JSS	Form 3	210	15-16 years
SSS	Form 4 and Form 5	1198	16-20 years
IHL	Year 1 to 4	950	18 years and above

In the selected junior secondary school, only the learners in form three were used because their ages were 15 and 16 years. The ages of other learners in junior secondary schools were below the age of 15 years.

A register of all learners who met the inclusion criteria was obtained from each school and learners were randomly selected from the register of each school to obtain a 10% sample size.

Francistown statistics office randomly selected Marang Super Spar from their computer for the researcher. The list of workplaces in Francistown was not disclosed to the researcher. Marang Super Spar had fifty two (52) workers on morning and afternoon shifts. The researcher made sure that only the individuals that met the inclusion criteria were selected. The Manager provided the researcher with a list of workers between the ages 15-25 years old. The workers were randomly selected from the 18 names provided and five (5) young workers voluntarily participated in the study. The selected respondents are shown in Table 3.3 below.

Table 3.3: Number of respondents selected.

	Total number	**Number of respondents (N)**
Junior secondary school	210	22
Senior secondary school	1198	120
Institution of higher learning	950	94
Work place	52	5
TOTAL	2410	241

3.4.3 Data collection instrument

The data collection instrument for the study was a questionnaire. Burns and Grove (2001:426) state that a questionnaire is a printed self-report form designed to elicit information and is developed with specific items to assist with the data collection. It is used to gather information from a large number of participants that can be easily quantified and analysed. A structured questionnaire was developed to elicit responses relevant to achieve the aim of the study. The aim of the questionnaire was to obtain information regarding the attitudes of the young people towards ñABCò strategy in the prevention of HIV/AIDS. The advantages of using a questionnaire to collect data in this study were that it required less time and energy to administer and that it was less costly (LoBiondo-Wood & Haber 2002:301). The other advantage stated by Polit et al (2001:269) was that the absence of an interviewer ensures that there was no bias in the responses that reflect the participantôs reaction to the interviewer rather than to the questions. Furthermore, there was greater assurance of anonymity and no interviewer bias.

3.4.3.1 Development of the questionnaire

In order to collect the needed data or information in the study, the researcher had to develop a measuring instrument to be given to all the participants, to ensure uniformity and consistency. The questions that were formulated were guided by the objectives of the study, the research questions and the Health Belief Model.

The literature relevant to the study, as well as other questionnaires used in similar studies provided valuable insight. Taylor, Peplau and Sears (2006:222) list the following criteria for the development of a questionnaire:

- The concept should be relevant to the study question
- Concepts should be translated into items
- One question per item
- Items should be worded clearly
- The most important items should be placed at the beginning of the questionnaire

Accordingly, the researcher developed a questionnaire in order to obtain the relevant information needed for this study. The instrument addressed issues concerning the attitudes of young people, the perceived susceptibility and severity to HIV/AIDS, factors that would affect the adoption of ñABCò strategy as well as its benefits. When designing the questionnaire the aspects quoted by Taylor et al (2006: 222) above were considered as well as the following:

- Avoidance of wording bias
- Clarity of the questions
- Ability of the respondent to give accurate information
- Length of the questionnaire
- Amount of time it would take respondent to complete the questionnaire
- Concepts under the conceptual framework

The design of the questionnaire took time and effort and it was drafted a number of times in consultation with the statistician and the supervisors of the study at the University of South Africa (UNISA) who critically reviewed and verified the interpretations of the questions in the questionnaire before being finalized. The questionnaire was also evaluated by experts in research unit under the Ministry of Health and experts in HIV/AIDS department under the Ministry of Education before they gave their consents to the researcher to carry on with the study.

3.4.3.1.1 Covering letter

The purpose of the study was explained to the young people in the covering letter that accompanied the questionnaires. Anonymity and confidentiality were assured to ensure that the identity of the young people who participated in the study could not be linked with their individual responses (Burns and Grove 2001:430). The covering letter requesting the participation of young people in the study is included as Annexure J

3.4.3.1.2 Structure of the questionnaire

A complete questionnaire is included as Annexure K. The questionnaire comprised the following sections:

SECTION A: BIOGRAPHICAL DATA

This section contained seven (7) questions which sought biographical information such as age, gender, marital status, residential address, schooling and employment status. Close-ended questions were used in this section. The purpose of eliciting such information was to secure a descriptive profile of respondents and to ensure a basis for data analysis in relation to other sections of the questionnaire as per objectives of the study.

SECTION B: ATTITUDE TOWARDS ABSTINENCE

This section contained questions designed to elicit information regarding the attitudes of young people towards abstinence; an aspect of ñABCòstrategy of HIV/AIDS prevention. A four point likert type scale was used in sections B, C and D using frequency responses; strongly agree, agree, disagree and strongly disagree.

SECTION C: ATTITUDE TOWARDS FAITHFULNESS

This section contained questions designed to elicit information regarding the attitudes of young people towards being faithful; an aspect of ñABCòstrategy of HIV/AIDS prevention.

SECTION D: ATTITUDE TOWARDS USE OF CONDOMS

This section contained questions designed to elicit information regarding the attitudes of young people towards the use of condoms; an aspect of ñABCòstrategy of HIV/AIDS prevention.

Questions were picked from sections B, C and D collectively to measure up with the six components of HBM that guided the study (see table 3.4 below).

Table 3.4 Questionnaire items related to the components of HBM towards the ñABCò strategy.

CONCEPTS OF THE HBM	**ITEMS IN THE QUESTIONNAIRE**
Perceived susceptibility	• If I love my partner I will not prove my love by having sex with him/her • It is possible to contract HIV/AIDS from a regular partner • Only the two people who trust each other completely should have sexual relations • If I love my partner I will prove my love for him/her by having sex with him/her without a condom
Perceived severity	• Using condom to prevent the spread of HIV/AIDS is more trouble than itôs worth • Condoms should be used in casual encounters and not in steady relationships • Use of condom with a steady partner indicates lack of trust
Perceived benefits	• Abstinence needs discipline and willpower • Faithfulness is very important in a relationship • Having sex with many people does not make sex more enjoyable • Using condom does not help to prevent HIV/AIDS
Perceived barriers	• Buying condom is embarrassing (*access to condoms*, *negative beliefs or attitudes about condom use)* • Condoms are not easy to use (lack of knowledge of the correct use of condoms) • It is boring to have the same sexual partner for a long time *(negative beliefs or attitudes about abstinence and condom use)* • Condom reduces the quality of sex so much that it is better not to use it at all
Cues to action	• Before engaging into sexual relation, one should think about it carefully • Sexual intercourse is not the only way two people can get to know each other
Self Efficacy	• I feel comfortable talking about abstinence • Abstinence is not difficult to practice • It is possible to postpone sexual relations until a person is able to take responsibility for his or her action • Discussing using condom with someone is not embarrassing • It is not compulsory to be engaged in sexual activities • If a person finds out that he or she has HIV/AIDS he or she has to talk about it with his or her partner • It is important that one can talk with his or her partner about HIV/AIDS

3.4.3.2 Pre-testing of the instrument

Polit and Hungler (1999:289) state that a pre-test is done with individuals who have similar characteristics to those who were used in the study. A pre-test of an instrument is a trial run for detecting inadequacies and unforeseen problems before going to the expense of a full-scale study. It is done to determine the clarity of questions, effectiveness of instructions, completeness of the response set and the time required to complete the questionnaire (Burns and Grove 2001:430). Polit, Beck and Hungler (2004:54) state that a pre-test aims to verify the level of inclusivity and acceptability of the questionnaire and improving the instrument if necessary and also testing the feasibility of the study.

With the permission obtained from the Ministry of Health, Ministry of Education, and from Francistown Senior Secondary School Francistown, the questionnaire was administered to a group of 20 young people aged 15-25 years and the people who participated in the pre-test were excluded from the actual study. The students commented that the questionnaire was not long because it did not take a long time to complete and that the questions were simple to understand.

3.4.3.3 Measures to ensure validity

Validity is defined as a measure of truth or falsity of the data obtained through using the research instrument (Burns and Grove 2001:226). Babbie (2001:142) defines validity as the degree to which an instrument measures what it is supposed to be measuring.

3.4.3.3.1 Content Validity

Polit, Hungler and Beck (2001:309) state that content validity is concerned with the adequacy of coverage of the content area being measured. Babbie (2001:144) indicates that content validity refers to how much a measure covers the range of meaning included within a concept. Due attention was paid by the researcher in the development of the questionnaire to ensure that the items included were representative of what needs to be elicited in accordance with the HBM. The procedure to establish

content related validity as suggested by Burns and Grove (2001:401) was followed and it includes literature review, the involvement of content experts and representatives of the relevant population.

The questionnaire was developed following extensive literature review using HBM which assisted the researcher to determine the boundaries of the study. Experts in the HIV/AIDS department under the Ministry of Education were requested to assess the questionnaire. The draft questionnaire was submitted to the supervisors of the study at UNISA and the statistical consultant. The questionnaire was only administered after a pre-test was done.

3.4.3.3.2 Face Validity

Face validity according to Polit et al (2001:309) refers to whether the instrument looks as though it is measuring the appropriate construct. Polit et al (2001:406) state that it is the extent to which a measuring instrument looks as though it is measuring what it purports to measure. The questionnaire was constructed so that it could measure the attributes to be studied which was the attitudes of young people towards ñABCò strategy for HIV/AIDS prevention. In ensuring face validity the questionnaire was subjectively assessed for presentation and the relevance of the questions. The questionnaire was evaluated by experts in research unit under the Ministry of Health.

3.4.3.4 Reliability of the instrument

Creswell (2002:180) indicates that reliability means that individual scores from an instrument should be nearly the same or stable on repeated administrations of the instruments. Test-retest method of reliability was conducted.

3.4.3.4.1 Test-Retest Reliability

Trochim (2006:1) explains that the test-retest reliability is used to assess the consistency of a measure from one time to another. This approach assumes that there is no substantial change in the construct being measured between the two occasions. Ten students were chosen to fill the questionnaires. All the 10 students filled the questionnaires twice at an average of two weeks and there were no dropouts. The correlation was calculated in order to estimate how consistently the students

responded to the same questions within the two weeks interval and reliability obtained was 0.941.

3.4.4 Data collection

Burns and Grove (2001:49-50) define data collection as the precise systematic gathering of information relevant to specific research objectives or questions. Data can be collected in several ways depending on the study and can include a variety of methods. However, the researchõs objective must be accomplished with the instrument used. Literature on research indicates that descriptive research data can be collected through the use of interviews and questionnaires (LoBiondo-Wood and Haber 2002:224; Polit et al 2001:186). The data for this study were gathered with the use of a questionnaire that was developed to achieve the research aim and objectives.

Polit et al (2001:186) state that self-adminstered questionnaires can be distributed in a number of ways such as through the e-mail, by post or to self-contained groups (eg. young people in a particular school). The questionnaires were administered with the assistance of the HIV/AIDS coordinator in each school. This method of administration simplified the process and ensured increased response rate.

3.4.5 Data analysis

Data analysis is a systematic organization and synthesis of research data, a testing of the research hypothesis using the data (Polit and Hungler 1999:643). Data collected for the study were cleaned, coded and analysed with the assistance of a statistical consultant. Descriptive and inferential statistics were used. Tables and figures were done on the computer using the Statistical Package for the Social Sciences (SPSS) version 13.0. This approach was chosen because the study aimed at quantifying the young peopleõs attitudes towards "ABCòstrategy. The researcher made no conclusion on the attitudes towards ñABCòstrategy for prevention but rather the researcher described the attitudes using the descriptive and inferential statistics.

3.5 ETHICAL CONSIDERATIONS

According to Polit and Hungler (1999:29) the protection of the rights of human subjects has become high priority among members of scientific and health care communities. In this research, ethical issues were taken into consideration taking into account the fact that HIV/AIDS is a very sensitive issue.

3.5.1 Permission to conduct the study

Once the approval of the research project was obtained from the Health Studies Research & Ethics Committee (HSREC) of the University of South Africa (Annexure B), the researcher sought approval from various schools and a work place. Before attempting to visit the secondary schools in Francistown, permission was sought from the relevant administrators to carry out the research and gain entry into the various selected schools.

The researcher made a request to conduct the study in writing to the Ministry of Health and Ministry of Education and permissions were granted (Annexure C and D). The selected schools were notified by the Ministry of Education of the researcherôs intention to carry out research in their schools. The researcher also requested permission to conduct the study from the principals of the selected secondary schools and permissions were given (Annexure E, F, and G)

The principals of the selected secondary schools directed the researcherôs letters to their various HIV/AIDS coordinators to assist the researcher carry on the study. Arrangements for administering the questionnaires to the students were made with the researcher and the HIV/AIDS coordinators. Letter of permission was also given and granted by the head of a higher institution in Francistown (Annexure H) and the student support service coordinator was assigned to assist the researcher. The researcher also obtained permission to conduct the study from the management of Super Spar (Annexure I).

3.5.2 Informed consent

The respondents were informed in writing that participation was voluntary and the purpose of the study and participation needed from the respondents were explained. All

respondents within the ages of 21-25 years gave their own written consent to participate in the study. The respondents less than 21 years of age participated under the written consent of their parents or guidance. During one of the parents/teachers association meetings (PTA), the parents were informed that their children under the age of 21 years but not younger than 15 years would bring questionnaire and consent to be signed if their children had been randomly selected. The parents or legal guardians of the respondents voluntarily signed the written consent on behalf of those under 21 years of age.

3.5.3 Anonymity and Confidentiality

The respondents were not expected to write their names on the questionnaires so that their names would not be linked to any particular completed questionnaire. The respondents were assured that the information would be used for the purpose of the research and the result of the research would be made available to them if they requested it.

3.5.4 Benefit

The respondents were informed that they would not receive any remuneration for participating in the study. They were however informed that their participation in the study would be appreciated because the information gathered will assist in planning future health education for young people.

3.5.5 Right to self determination

The respondents were informed that they had the right to decide voluntarily whether to participate in the study without the risk of incurring any penalty and that they had the right to ask questions, to refuse to give information or to terminate their participation meaning that they could withdraw from the study.

3.6 OPERATIONALIZATION OF DATA COLLECTION

Two hundred and fifty two (252) questionnaires were delivered to the HIV/AIDS coordinators and the student support coordinator in selected secondary schools and the institution of higher learning .

Five (5) questionnaires were delivered to the selected workplace making it a total number of 257 questionnaires. The participants filled in the questionnaires after the purpose of the study was explained and they had signed the informed consent. The learners were approached in their various classes and the young people at the work place were approached individually at their work place. They were all given 48 hours to fill and return the questionnaires after their consent had been obtained. Some of the respondents that gave their own consent returned their filled questionnaires on the same day of administration. Some returned after 48 hours of receipt. The researcher waited for a period of 10 working days to ensure that all the questionnaires were collected especially collecting from the students of the institution of higher learning. The total number of questionnaires returned was 241 and they were used for the analysis of the study.

3.6.1 Response to the questionnaire

Responses that were received up to the 10 working days the researcher used for collecting the questionnaire were included in the study. Table 3.5 below indicates the number of responses to the questionnaire.

Table 3.5: Response to the questionnaire

Sites selected	**Number of questionnaires distributed**	**Percentage**	**Number of questionnaires returned**	**Percentage**
Junior secondary school	22	100%	22	100%
Senior secondary school	130	100%	120	92%
Institute of higher learning	100	100%	94	94%
Work place	5	100%	5	100%
Total	257	100%	241	93.8%

According to Johnson and Christensen (2004:112) response rate around 70% and higher is generally considered acceptable. The response rate the researcher obtained was 93.8% which was good and acceptable for the study.

3.7 CONCLUSION

The chapter dealt with the research methodology that was used for the study addressing the population, research setting, data collection instrument, recruitment of study participants, data collection, data analysis, ethical issues that were carried out in the study. In the next chapter, the analysis of the data collected will be discussed.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the data analysis and interpretation. The data were analysed using the statistical package for social sciences (SPSS) version 13.0. The analysis provided frequencies, percentages and t-test results, and the findings were presented mainly in tables and figures. The main sections and sub-sections of the questionnaire were highlighted. The percentages in the tables and figures were presented as received from the data analysis software but the percentages have been rounded up.

4.2 DATA ANALYSIS

As indicated in Chapter 1, the purpose of the study was to determine the attitudes of young people aged 15ï 25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana.

The objectives of the study were to:

- Describe the attitude of young people aged 15ï 25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana.
- Establish if the attitudes of young people aged 15ï 25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana differ for males and females
- Establish if the attitudes of young people aged 15ï 25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana differ for age groups 15-19 years and 20-25 years
- Make recommendations regarding the strategies that can be used to foster positive attitudes in young people aged 15ï 25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana.

The number of questionnaires distributed was 257 but a total number of 241 young people aged 15-25 years participated in the study, they completed and returned the questionnaire giving a response rate of 93.8%.

Data analysis was done with the assistance of a statistician. Descriptive and inferential statistics were used in the data analysis. Statistical significance of the groups was done using t-test analysis. T-test compared groups to establish if the difference between them was statistically significant.

4.3 RESULTS

4.3.1 Characteristics of the study participants

4.3.1.1 Age

The ages of the respondents are shown in figure 4.1. A large number of respondents 150 (62%) were in the age range 15-19 years. Ninety one (38%) was in the age range 20-25 (refer to Figure 4.1 below).

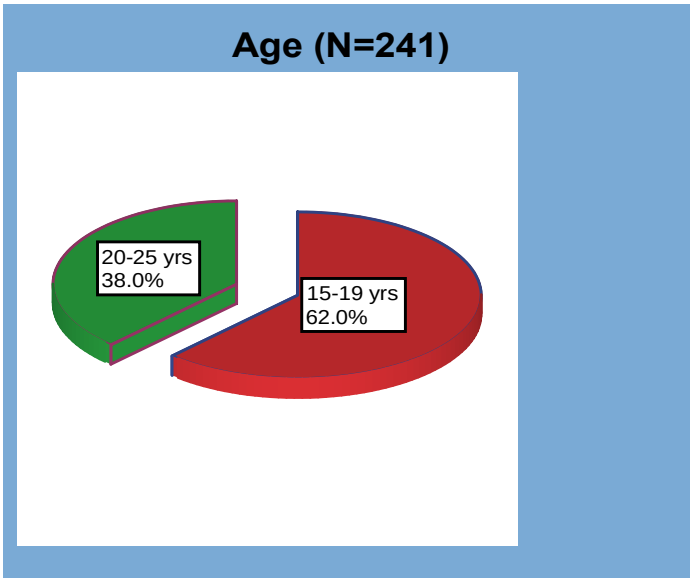

Figure 4.1

Ages of respondents

4.3.1.2 Gender

Figure 4.2 below shows the gender of respondents. Ninety six (40%) of the respondents were males and 145(60%) were females.

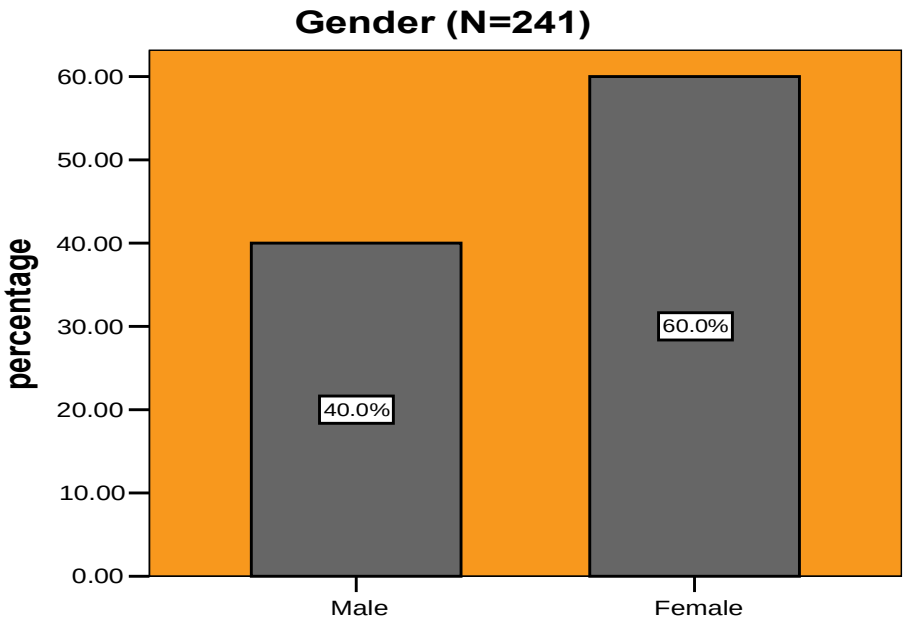

Figure 4.2

Gender of the respondents

Table 4.1 below shows the number of males and females in each age group. In the age group 15-19, 56 (37%) were males while 94 (63%) were females. Forty (44%) in the age group 20-25 were males whereas 51 (56%) were females.

Table 4.1: Number of males and females in each age group (n=241)

15-19 years n=150		**20-25 years N= 91**		**Total 241**
Male(n)	Female(n)	Male(n)	Female(n)	
56(37%)	94(63%)	40(44%)	51(56%)	241 (100%)

4.3.1.3 Marital status

A large number of respondents 232 (96%) were single, followed by 8 (3%) married respondents. Only 1(1%) respondent was divorced. Those aged 15-19 were

all single (see table 4.2 below). Of the age group 20ï 25, 8(9%) were married and 82 (90%) were single.

Table 4.2: Marital status of the respondents (N=241)

	Frequency (15-19 yrs)	Frequency (20-25 yrs)	Total
Married	-	8 (9%)	8 (3%)
Single	150 (100%)	82 (90%)	232 (96%)
Divorced	-	1 (1%)	1 (1%)
Total	150 (62%)	91 (38%)	241 (100%)

4.3.1.4 Place of residence

All the 241 (100%) respondents lived in Francistown at the time the study was conducted. The study sought to describe the attitude of young people aged 15-25 regarding the ñABCòstrategy of HIV/AIDS prevention in Francistown, so it was important to establish the place of residence of the respondents to ensure that the respondents met the inclusion criteria.

4.3.1.5 School attendance

The majority of the respondents 236 (98%) were attending school at the time when the study was conducted. Five (2%) of the respondents were employed.

4.3.1.6 Level of education

All the respondents had a level of education at one time in their life or were still in the system of education. Twenty four (10%) respondents had junior secondary level of education, 123 (51%) had senior secondary level of education and 94 (39%) had higher level of education (see figure 4.3 below).

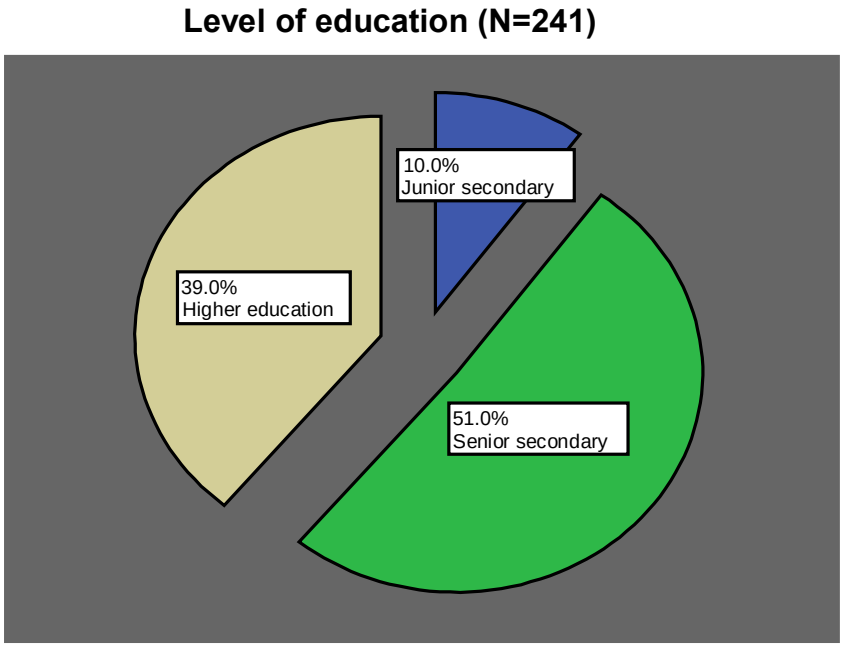

Figure 4.3

Level of education of the respondents

4.3.1.7 Employment status of respondents

Only five (2%) respondents were employed, one respondent was in the age group 15-19 years and four in the age group of 20-25 years.

4.3.2 Responses to specific research questions

4.3.2.1 Attitude towards abstinence of young people aged 15-25 years (n=241)

Section B of the questionnaire consisted of eight items which collected information about respondentsôattitude towards abstinence. The objective was to describe the attitudes of young people aged 15ï 25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana. Table 4.3 shows attitudes of young people aged 15ï 25 years towards abstinence, a component of ñABCòstrategy in the prevention of HIV/AIDS. The frequency responses of *agree and strongly agree* were interpreted as positive attitude and *disagree and strongly disagree* as negative attitude. The response *not sure* was interpreted as ambivalent.

Table 4.3: Responses to abstinence of young people

	STRONGLY AGREE		**AGREE**		**DISAGREE**		**STRONGLY DISAGREE**		**NOT SURE**		**Total**	
	n	**%**	**n**	**%**	**N**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Abstinence is not difficult to practice	48	22	45	18	**60**	26	25	10	**63**	24	241	100
It is not compulsory to be engaged in sexual activities	**94**	37	**63**	28	38	17	15	6	31	12	241	100
I feel comfortable talking about abstinence	**100**	40	**91**	39	27	9	-	-	23	12	241	100
Abstinence needs discipline and will power	**130**	54	**86**	38	25	8	-	-	-	-	241	100
Sexual intercourse is not the only two people can get to know each other	**156**	62	**72**	32	13	6	-	-	-	-	241	100
Before engaging into sexual relations one should think about it carefully	**143**	58	**89**	38	5	2	-	-	4	2	241	100
It is possible to postpone sexual relations until a person is able to take responsibility for his or her action	27	10	43	19	**91**	36	**57**	23	23	12	241	100
If I love my partner I will not prove my love for him/her by having sex with him/her	**45**	16	42	20	15	7	14	6	**125**	51	241	100

4.3.2.1.1 Abstinence is not difficult to practice

The young people who strongly agreed that abstinence is not difficult to practice were 48 (22%), 45 (18%) agreed, 60 (26%) disagreed, 25 (10%) strongly disagreed while 63 (24%) were not sure with the statement**.**

4.3.2.1.2 It is not compulsory to be engaged in sexual activities

Ninety four (37%) young people aged 15-25 years strongly agreed, 63 (28%) agreed, 38 (17%) disagreed, 15 (6%) strongly disagreed while 31 (12%) were not sure if it is not compulsory to be engaged in sexual activites.

4.3.2.1.3 I feel comfortable talking about abstinence

The number of respondents, 100 (40%),strongly agreed that they feel comfortable talking about abstinence, 91 (39%) agreed, 27 (9%) disagreed 23 (12%) were not sure with the statement. No respondent strongly disagreed with the statement.

4.3.2.1.4 Abstinence needs discipline and will power

Most of the young people 130 (54%) strongly agreed with the stated item ñ*Abstinence needs discipline and will power",* 86 (38%) agreed, 25 (8%) disagreed while none of the respondents strongly agreed or were not sure.

4.3.2.1.5 Sexual intercourse is not the only way two people can get to know each other

One hundred and fifty six (62%) respondents strongly agreed, 72 (32%) agreed, 13 (6%) disagreed while none strongly disagreed or were not sure that sexual intercourse is the only way two people can get to know each other.

4.3.2.1.6 Before engaging into sexual relations one should think about it carefully

Among the young people aged 15-25 years, 143 (58%) strongly agreed that one should think carefully before he or she engages in sexual activities, 89 (38%) agreed, 5 (2%) disagreed, none strongly disagreed and 4 (2%) were not sure.

4.3.2.1.7 It is possible to postpone sexual relations until a person is able to take responsibility for his or her action

Responses from young people showed that 27 (10%) strongly agreed that one can postpone sexual relations until he or she is able to take responsibility for his or her action, 43 (19%) agreed, 91 (36%) disagreed, 57 (23%) strongly disagreed while 23 (12%) were not sure.

4.3.2.1.8 If I love my partner I will not prove my love for him/her by having sex with him/her

The young people aged 15-25 years that strongly agreed were 45 (16%), 42 (20%) agreed, 15 (7%) disagreed, 14 (6%) strongly disagreed that if they love their partner, they will not prove their love by having sex with their partners. The number that were not sure was 125 (51%).

4.3.2.2 Attitude towards being faithful of young people aged 15-25 years (n=241)

Section C of the questionnaire consisted of seven items which collected information about respondentsôattitude towards being faithful. Table 4.4 shows responses to questions on attitudes of young people aged 15ï 25 years towards being faithful, a component of ñABCò strategy in the prevention of HIV/AIDS. The frequency responses *strongly agree* and *agree* were combined and reported as describing the positive attitude towards being faithful. The frequency responses *disagree* and *strongly disagree* were combined and reported as describing the negative attitude towards being faithful except in question six which reverse is the case. The response *not sure* was interpreted as ambivalent.

Table 4.4: Young peoples responses regarding being faithful to one sexual partner ***(n=241)***

	STRONGLY AGREE		**AGREE**		**DISAGREE**		**STRONGLY DISAGREE**		**NOT SURE**		**TOTAL**	
	n	**%**	**n**	**%**	**N**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Faithfulness is very important in a relationship	**139**	59	**102**	41	-	-	-	-	-	-	241	100
It is possible to contract HIV/AIDS from a regular partner	**62**	25	**83**	37	33	15	28	9	35	14	241	100
If a person finds out that he or she has HIV/AIDS he/she has to talk about it with his/her partner	12	6	**103**	41	21	9	6	2	**99**	42	241	100
It is important that one can talk with his or her partner about HIV/AIDS	**110**	43	**129**	56	-	-	-	-	2	1	241	100
Only the two people who trust each other completely should have sexual relations	-	-	-	-	**42**	15	**186**	81	13	4	241	100
It is boring to have the same sexual partner for a long time	4	2	**56**	29	**89**	34	**56**	19	36	16	241	100
Having sex with many people does not make sex more enjoyable	**66**	23	30	16	38	17	34	19	**73**	25	241	100

4.3.2.2.1 Faithfulness is very important in a relationship

One hundred and thirty nine (59%) strongly agreed, 102 (41%) agreed while none of the respondent disagreed, strongly disagreed or were not sure if faithfulness is important in a relationship.

4.3.2.2.2 It is possible to contract HIV/AIDS from a regular partner

The young people that strongly agreed that it is possible to contract HIV/AIDS from a regular partner were 62 (25%), 83 (37%) agreed, 33 (15%) disagree, 28 (9%) strongly disagreed while 35 (14%) were not sure.

4.3.2.2.3 If a person finds out that he or she has HIV/AIDS he/she has to talk about it with his/her partner

The young people aged 15-25 years were asked if a person finds out that he or she has HIV/AIDS, if he or she would talk with partner about it, 12 (6%) strongly agreed, 103 (41%) agreed, 21 (9%) disagreed, 6 (2%) strongly disagreed while 99 (42%) were not sure.

4.3.2.2.4 It is important that one can talk with his or her partner about HIV/AIDS

A hundred and ten (43%) strongly agreed, 129 (56%) agreed, 2 (1%) were not sure while none disagreed or strongly disagreed that it is important that one talk with his or her partner about HIV/AIDS.

4.3.2.2.5 Only the two people who trust each other completely should have sexual relations

None of the respondents strongly agreed or agreed that only the two people who trust each other completely should have sexual relations. Fourty two (15%) disagreed, 186 (81%) strongly disagreed while 13 (4%) were not sure.

4.3.2.2.6 It is boring to have the same sexual partner for a long time

Only four (2%) strongly agreed to the stated item *"It is boring to have the same sexual partner for a long time",* 56 (29%) agreed, 89 (34%) disagreed, 56 (19%) strongly disagreed while 36 (16%) were not sure.

4.3.2.2.7 Having sex with many people does not make sex more enjoyable
Sixty six (23%) strongly agreed that having sex with many people does note make sex more enjoyable. Thirty (16%) agreed, 38 (17%) disagreed, 34 (19%) strongly agreed while 73 (25%) were not sure.

4.3.2.3 Attitude towards condom of young people aged 15-25 years (n=241)
Section D of the questionnaire consisted of nine items which collected information about respondentsôattitude towards condoms. Table 4.5 shows attitudes of young people aged 15ï 25 years towards condoms, a component of ñABCò strategy in the prevention of HIV/AIDS. The frequency responses *strongly agree* and *agree* were combined and reported as describing the negative attitude towards condom. The frequency responses *disagree* and *strongly disagree* were combined and reported as describing the negative attitude towards abstinence except question six where reverse is the case. The response *not sure* was interpreted as ambivalent.

Table 4.5: Young peoplesôresponses regarding condom ***(n=241)***

	STRONGLY AGREE		**AGREE**		**DISAGREE**		**STRONGLY DISAGREE**		**NOT SURE**		**TOTAL**	
	n	**%**	**n**	**%**	**N**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Using condom does not help to prevent HIV/AIDS	4	2	2	1	**129**	56	**106**	41	-	-	241	100
If I love my partner I will prove my love for him/her by having sex with him or her without a condom	-	-	25	11	**128**	49	43	19	**45**	21	241	100
Buying condom is embarrassing	**82**	29	**72**	26	15	6	**69**	38	3	1	241	100
Using condom to prevent the spread of HIV/AIDS is more trouble than its worth	-	-	-	-	**117**	46	**124**	54	-	-	241	100
Condoms are not easy to use	-	-	-	-	**77**	30	**139**	69	2	1	241	100
Discussing using condom with someone is not embarrassing	20	11	31	17	**67**	25	**65**	23	58	24	241	100
Condoms reduces the quality of sex so much that it is better not to use it at all	-	-	21	10	**98**	37	**106**	48	16	5	241	100
Condoms should be used in casual encounters and not in steady relationships	41	18	**69**	34	33	13	**60**	20	38	15	241	100
Use of condom with a steady partner indicates lack of trust	**62**	30	**142**	53	19	9	7	4	11	4	241	100

4.3.2.3.1 Using condom does not help to prevent HIV/AIDS

The young people aged 15-25 years that strongly agreed were 4 (2%), 2 (1%) agreed, 129 (56%) disagreed, 106 (41%) strongly disagreed that condom use does not help to prevent HIV/AIDS. No respondent was not sure.

4.3.2.3.2 If I love my partner I will prove my love for him/her by having sex with him or her

None of the respondents strongly agreed that if they love their partners, they will prove their love by having sex with him or her, 25 (11%) agreed, 128 (49%) disagreed, 43 (19%) strongly disagreed while 45 (21%) were not sure with the statement.

4.3.2.3.3 Buying condom is embarrassing

Eighty two (29%) of young people aged 15-25 years strongly agreed that buying condom is embarrassing, 72 (26%) agreed, 15 (6%) disagreed, 69 (38%) strongly disagreed while 3 (1%) were not sure.

4.3.2.3.4 Using condom to prevent the spread of HIV/AIDS is more trouble than its worth

None of the respondents strongly agreed, agreed or were not sure that using condom to prevent the spread of HIV/AIDS is more trouble than its worth. A hundred and seventeen (46%) disagreed while 124 (54%) strongly disagreed.

4.3.2.3.5 Condoms are not easy to use

None of the respondents strongly agreed or agreed that condoms are not easy to use. Only 2 (1%) were not sure, 77 (30%) disagreed while 139 (69%) strongly disagreed.

4.3.2.3.6 Discussing using condom with someone is not embarrassing

Twenty (11%) strongly agreed, 31 (17%) agreed, 67 (25%) disagreed, 65 (23%) strongly disagreed while 58 (24%) were not sure that discussing using condom with someone is not embarrassing.

4.3.2.3.7 Condoms reduces the quality of sex so much that it is better not to use it at all
None of the respondents strongly agreed that condom reduces quality of sex so much that it is better not to use it at all. Twenty one (10%) agreed, 98 (37%) disagreed, 106 (48%) strongly disagreed while 16 (5%) were not sure with the statement.

4.3.2.3.8 Condoms should be used in casual encounters and not in steady relationships
Fourty one (18%) strongly agreed, 69 (34%) agreed, 33 (13%) disagreed, 60 (20%) strongly disagreed while 38 (15%) were not sure that condoms should be used in casual encounters and not in steady relationships.

4.3.2.3.9 Use of condom with a steady partner indicates lack of trust
Sixty two (30%) of the young people aged 15-25 years strongly agreed that the use of condom with a steady partner indicates lack of trust, 142 (53%) agreed, 19 (9%) disagreed, 7 (4%) strongly disagreed while 11 (4%) were not sure.

4.3.3 Responses to specific research questions according to gender and age group

Another objective of the study was to establish if the attitudes of young people aged 15ï 25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana differed for males and females as well as age groups 15-19 and 20-25 years. The report on attitudes of young people was done according to age categories of 15-19 and 20-25 and gender in order to show comparison of attitudes between the two age groups and between males and females.

4.3.3.1 Attitude towards abstinence by gender

4.3.3.1.1 Abstinence is not difficult to practice
Figure 4.4 below presents the responses of males and females regarding the questionnaire item, ñ*Abstinence is not difficult to practice".*

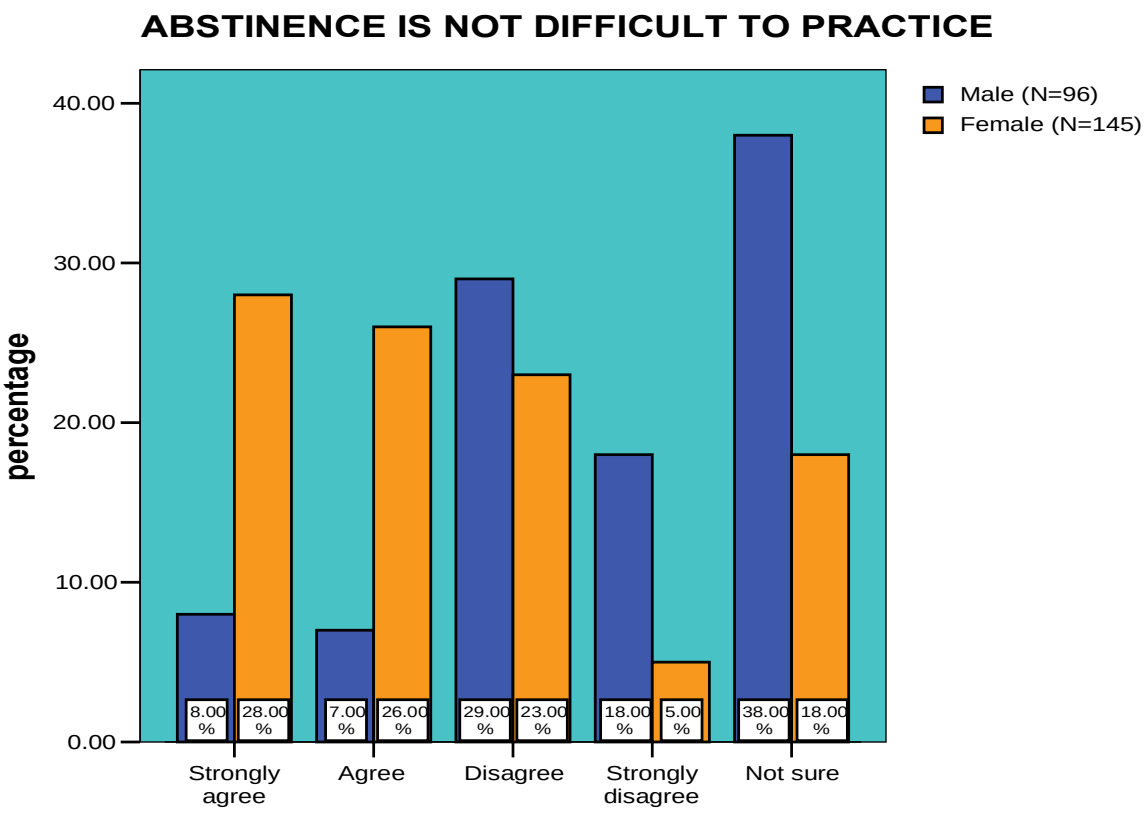

Figure 4.4

Abstinence not being difficult to practice by gender

Of the respondents in the male group, the highest was 36(38%) who were not sure if abstinence is difficult to practice or not, then followed by 28 (29%) that disagreed, followed by 17 (18%) that strongly disagreed, followed by 8 (8%) that strongly agreed then followed by 7 (7%) that agreed.

Table 4.6: t-test result for abstinence not being difficult to practice by gender

N	10			
Groups	N	Mean	SE	SD
Male	5	19.2	5.65	12.6
Female	5	29.0	5.78	12.9
Mean difference	-9.8			
95% CI	-28.4	to 8.8		
SE	8.08			
t statistic	-1.21			
DF	8.0			
2-tailed p	0.2600			

Since 0.2600 >0.05 the difference between the males and the females was not statistically significant (table 4.6).

4.3.3.1.2 It is not compulsory to be engaged in sexual activities

Figure 4.5 below shows the male and female responses to the item ñ*it is not compulsory to be engaged in sexual activities".*

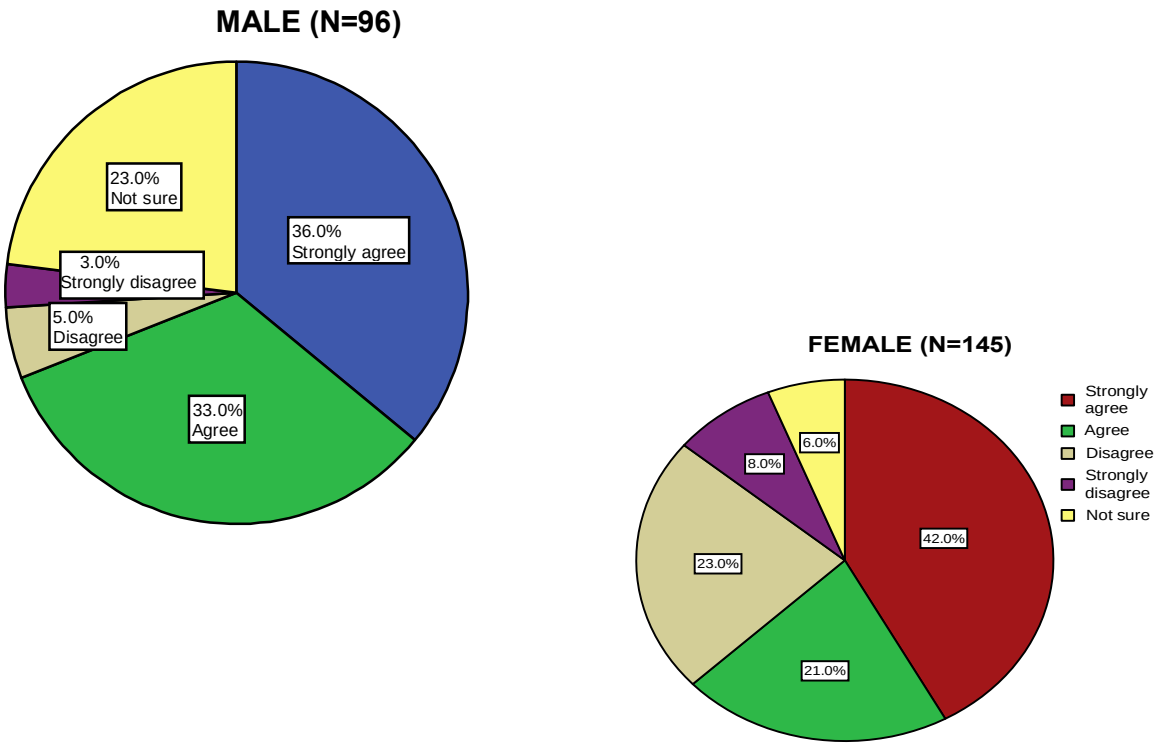

Figure 4.5

Sexual activities not being compulsory to be engaged into by gender

Thirty four (36%) male respondents to 60 (42%) female respondents strongly agreed that it is not compulsory to be engaged in sexual activities while 32 (33%) males to 31 (21%) females agreed with the statement. Five (5%) males to 33 (23%) females disagreed, 3 (3%) males to 12 (8%) females strongly disagreed. Sixteen (23%) males to 9 (6%) of females were not sure that it is not compulsory to be engaged in sexual activities.

Table 4.7: t-test result for sexual activities not being compulsory to be engaged into by gender

N	10			
Groups	N	Mean	SE	SD
Male	5	19.2	6.54	14.6
Female	5	29.0	9.14	20.4
Mean difference	-9.8			
95% CI	-35.7	to 16.1		
SE	11.24			
t statistic	-0.87			
DF	8.0			
2-tailed p	0.4085			

The difference between the males and females was not statistically significant (0.4085 >0.05 table 4.7).

4.3.3.1.3 I feel comfortable talking about abstinence

Figure 4.6 below presents the males and females attitudes about feeling comfortable talking about abstinence.

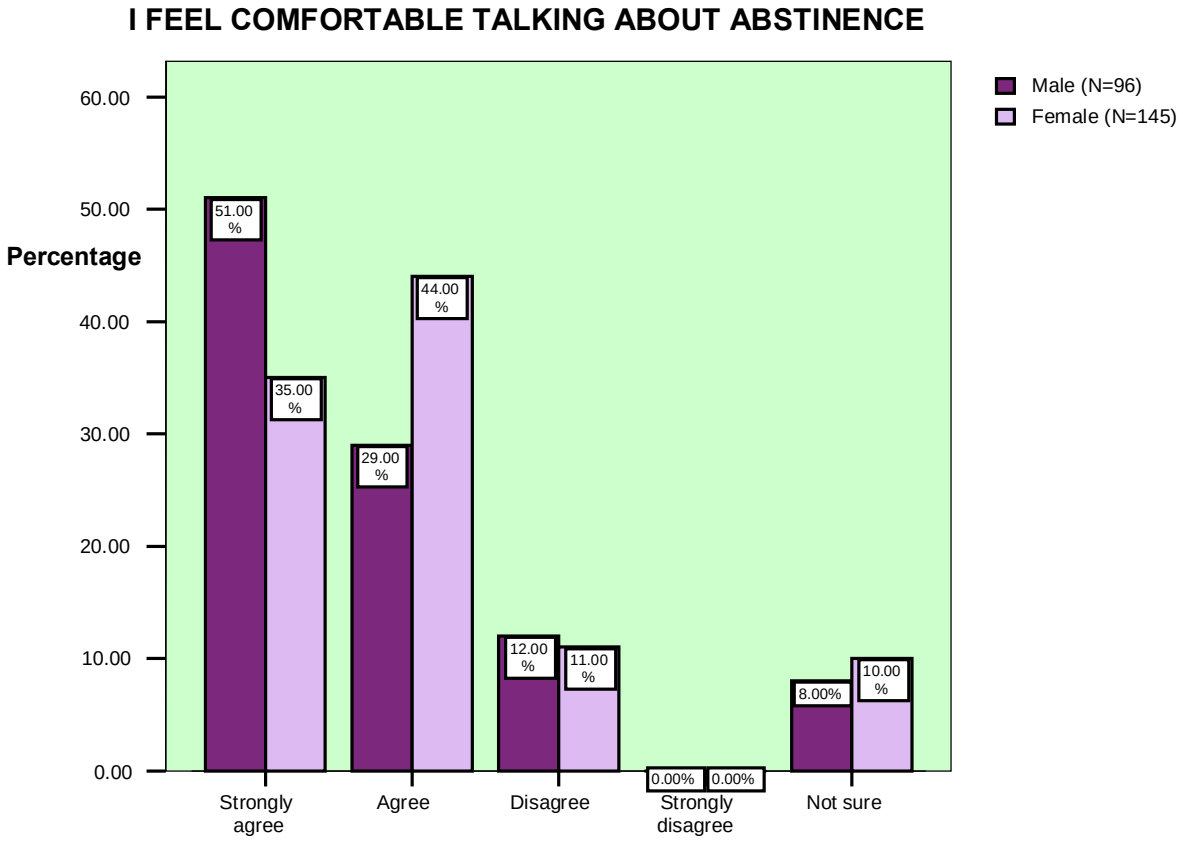

Figure 4.6

Talking about abstinence comfortably by gender

Responses from the male respondents showed that 49 (51%) strongly agreed, 28 (29%) agreed, 11 (12%) disagreed, no respondent strongly disagreed and 8 (8%) were not sure if they feel comfortable talking about abstinence.

Responses from the female respondents indicated that 51 (35%) strongly agreed, 63 (44%) agreed, 16 (11%) disagreed, no respondent strongly disagreed and 15 (10%) were not sure if they feel comfortable talking about abstinence.

Table 4.8: t-test result for talking about abstinence comfortably by gender

N	10			
Groups	n	Mean	SE	SD
Male	5	19.2	8.74	19.5
Female	5	29.0	11.93	26.7
Mean difference	-9.8			
95% CI	-43.9	to 24.3		
SE	14.79			
t statistic	-0.66			
DF	8.0			
2-tailed p	0.5261			

The difference between the males and the females was not statistically significant (0.5261 >0.05 table 4.8).

1.4 Abstinence needs discipline and will power

Figure 4.7 below shows the responses of males and females to the stated item above. None of the respondents in the male and female group strongly disagreed or were not sure that abstinence needs discipline and willpower. Fourty one (43%) males strongly agreed, 47 (49%) agreed while 8 (8%) disagreed that abstinence needs discipline and will power.

In the female group, 89 (61%) strongly agreed, 39 (27%) agreed while 17 (12%) disagreed that abstinence needs discipline and willpower.

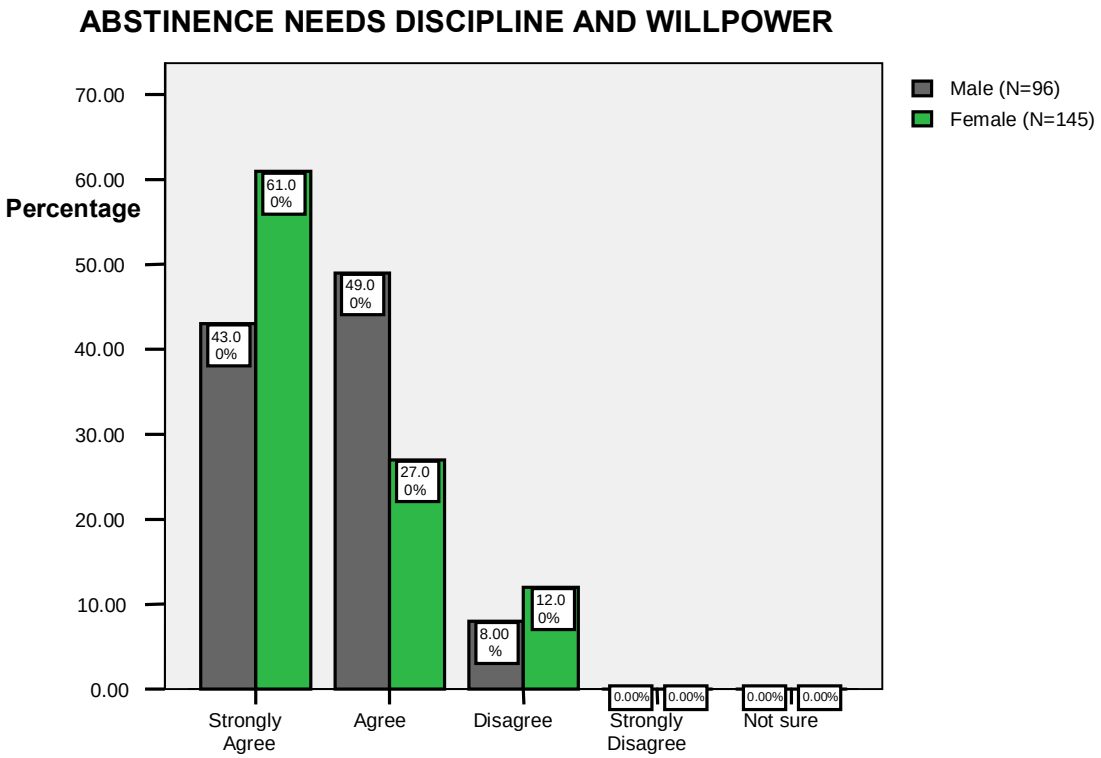

Figure 4.7

Abstinence needing discipline and willpower by gender

Table 4.9: t-test result for abstinence needing discipline and willpower by gender

N	10			
Groups	n	Mean	SE	SD
Male	5	19.2	10.27	23.0
Female	5	29.0	16.62	37.2
Mean difference	-9.8			
95% CI	-54.9	to 35.3		
SE	19.54			
t statistic	-0.50			
DF	8.0			
2-tailed p	0.6295			

There was no statistical significant difference between the male and female group (0.6295 >0.05 table 4.9).

4.3.3.1.5 Sexual intercourse is not the only way two people can get to know each other

Figure 4.8 presents the responses of males and females towards the stated item above.

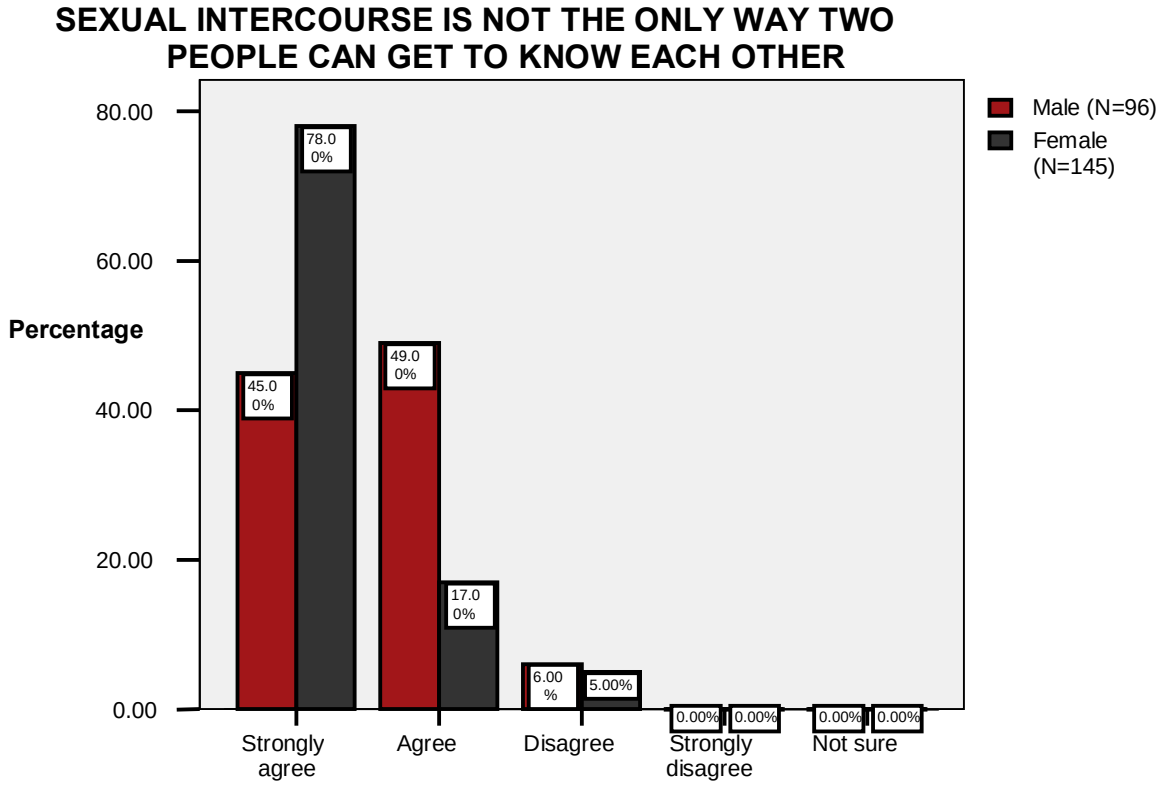

Figure 4.8

Sexual intercourse not being the only way to know each other by gender

Forty three (45%) males strongly agreed while 47 (49%) males agreed that sexual intercourse is not the only way two people can get to know each other. Six (6%) disagreed while none of the respondents from both male and female respondents strongly disagreed or were not sure with the statement.

Among the female respondents 113 (78%) strongly agreed and 25 (17%) agreed while 7 (5%) disagreed with the statement.

Table 4.10: t-test result for sexual intercourse not being the only way to know each other by gender

n	10			
Groups	n	Mean	SE	SD
Male	5	19.2	10.61	23.7
Female	5	29.0	21.49	48.1
Mean difference	-9.8			
95% CI	-65.1	to 45.5		
SE	23.97			
t statistic	-0.41			
DF	8.0			
2-tailed p	0.6933			

There was no statistical significant difference between males and females (0.6933 >0.05 table 4.10).

4.3.3.1.6 Before engaging in sexual relation, one should think about it carefully

Figure 4.9 below shows the male and female responses to the stated item above.

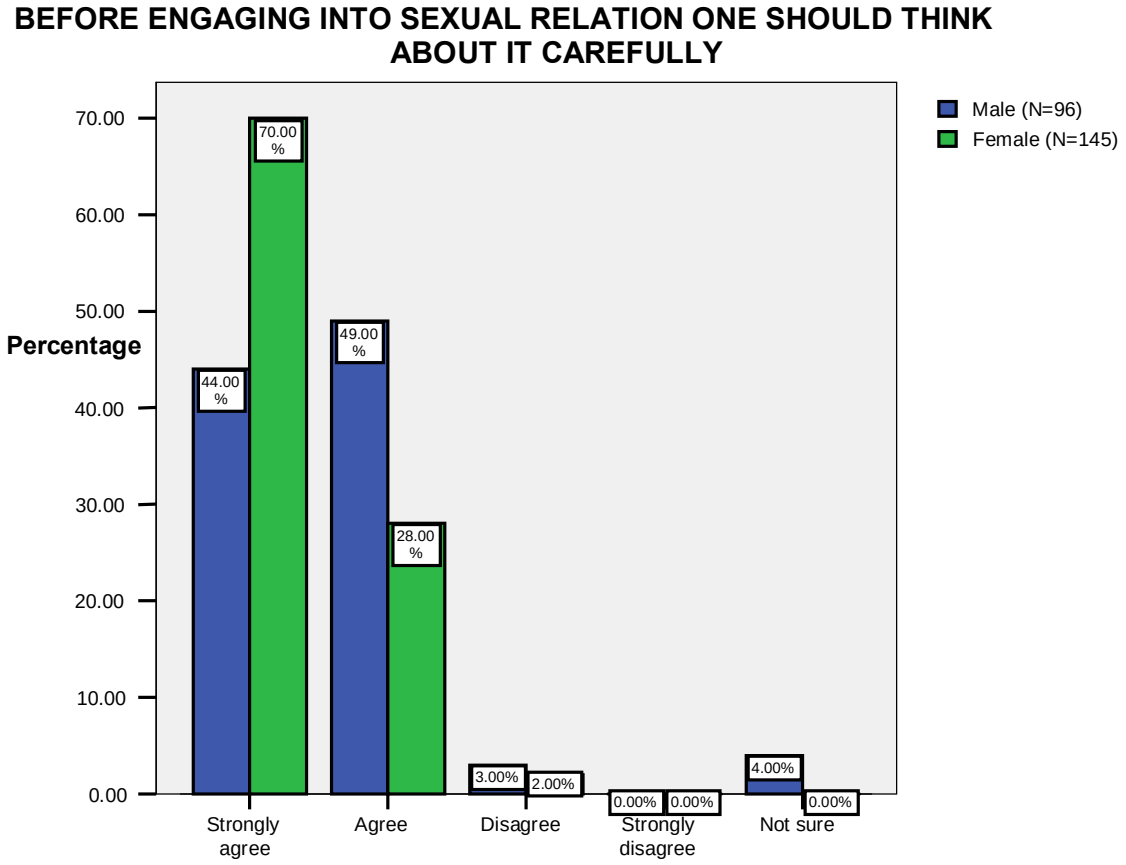

Figure 4.9

Thinking carefully before engaging into sexual intercourse by gender

A hundred and one (70%) female respondents had the highest percentage and strongly agreed that before someone engages into sexual relation one should think about it carefully. Fourty two (44%) male respondents strongly agreed. Forty seven (49%) males agreed to 41 (28%) females. Only 3 (3%) of the males and 3 (2%) of the females disagreed while only 4 (4%) of the male respondents were not sure to 0 (0%) females. No respondent in the male and female group strongly agreed with the statement.

Table 4.11: t-test result for thinking carefully before engaging into sexual intercourse by gender

n	10			
Groups	n	Mean	SE	SD
Male	5	19.2	10.38	23.2
Female	5	29.0	19.60	43.8
Mean difference	-9.8			
95% CI	-61.0	to 41.4		
SE	22.18			
t statistic	-0.44			
DF	8.0			
2-tailed p	0.6703			

There was no statistical significant difference between the male and female group (0.6703 >0.05 table 4.11).

4.3.3.1.7 It is possible to postpone sexual relations until a person is able to take responsibility for his or her action

Figure 4.10 below shows the responses of males and females towards the stated item above.

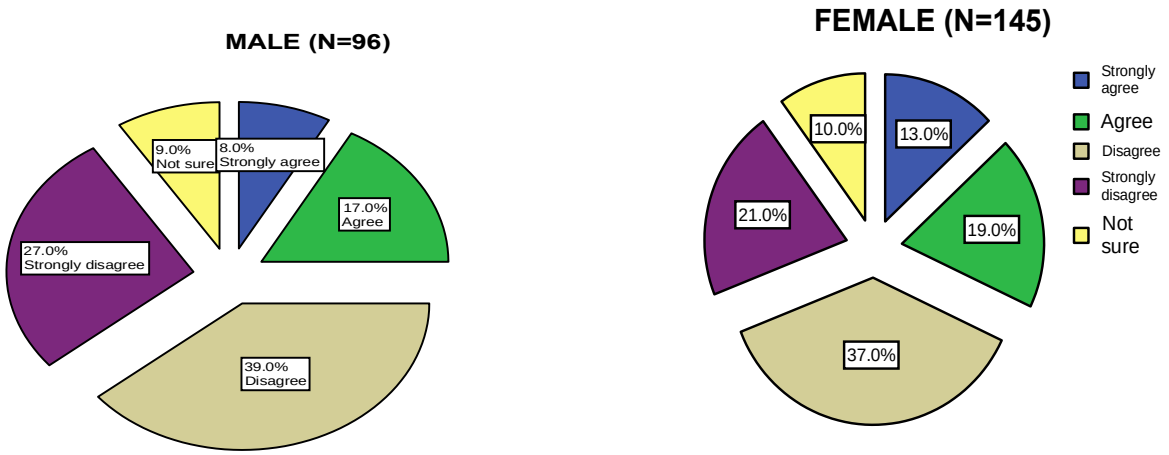

Figure 4.10

Postponing sexual relation by gender

Eight (8%) male respondents strongly agreed, 16 (17%) agreed, 37 (39%) disagreed, 26 (27%) strongly disagreed that it is possible to postpone sexual relations until a person is able to take responsibility for his or her action. Nine (9%) were not sure Nineteen (13%) of the female respondents strongly agreed, 27 (19%) agreed, 54 (37%) disagreed, 31 (21%) strongly disagreed and 14 (10%) were not sure to the stated item above.

Table 4.12: t-test result for postponing sexual relations by gender

n	10			
Groups	n	Mean	SE	SD
Male	5	19.2	5.49	12.3
Female	5	29.0	6.92	15.5
Mean difference	-9.8			
95% CI	-30.2	to 10.6		
SE	8.83			
t statistic	-1.11			
DF	8.0			
2-tailed p	0.2995			

There was no statistical significant difference between the male and female group (0.2995 >0.05 (table 4.12 above).

4.3.3.1.8 If I love my partner I will not prove my love for him /her by having sex with him/her

Figure 4.11 shows the responses of males and females towards the stated item above.

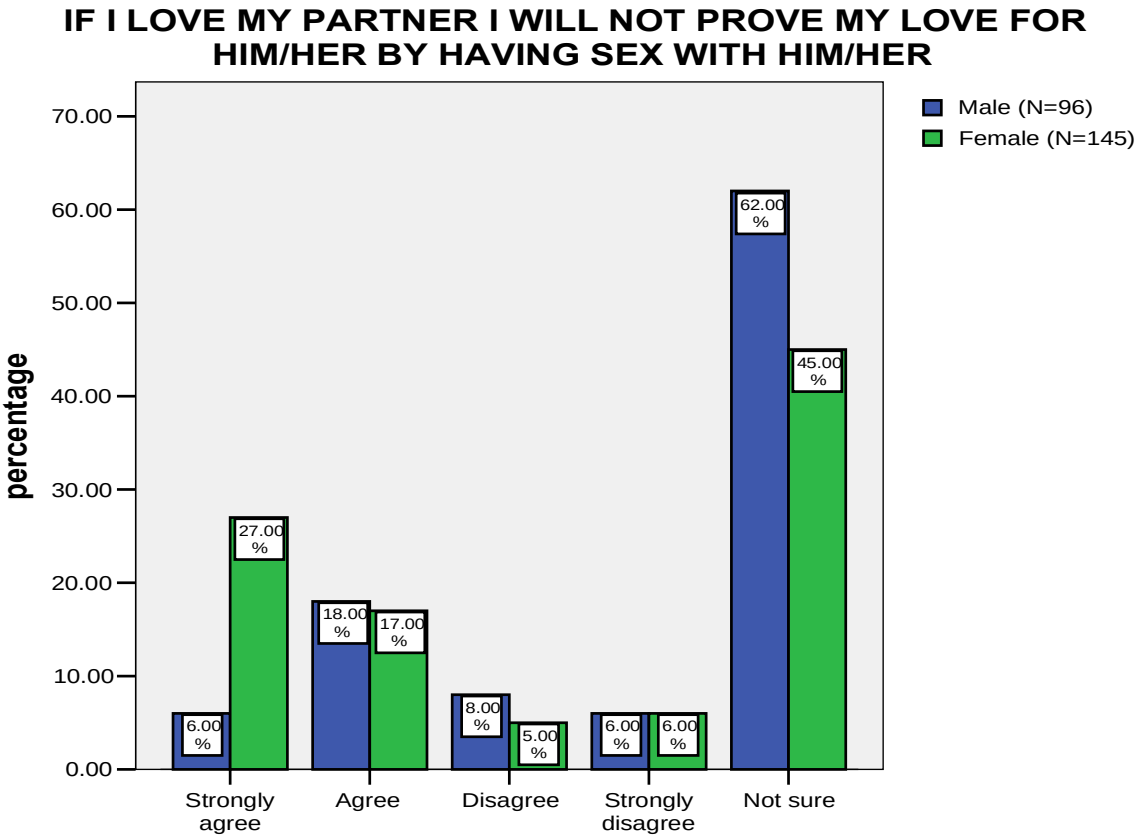

Figure 4.11

Proof of love by gender

Fifty nine (62%) male respondents who were not sure had the highest percentage followed by 17 (18%) who agreed, followed by 8 (8%) who disagreed then followed by 6 (6%) who strongly agreed and strongly disagreed to the stated item above.

Thirty nine (27%) females strongly agreed, 25 (17%) agreed, 7 (5%) disagreed, 8 (6%) strongly disagreed that if they love their partners they will not prove their love by having sex with their partners. Sixty six (45%) females were not sure.

Table 4.13: t-test result for proof of love by gender

n	10			
Groups	n	Mean	SE	SD
Male	5	19.2	10.16	22.7
Female	5	29.0	10.98	24.5
Mean difference	-9.8			
95% CI	-44.3	to 24.7		
SE	14.95			
t statistic	-0.66			
DF	8.0			
2-tailed p	0.5307			

There was no statistical significant difference between the male and female group (0.5307 >0.05 (table 4.13).

4.3.3.2 Attitude towards abstinence by age group

The report on attitudes of young people was done according to age ranges of 15-19 and 20-25 in order to show comparison of attitudes between the two age groups. This is in line with the objectives of the study.

4.3.3.2.1 Abstinence is not difficult to practice

Figure 4.12 shows the responses of young people to the item stated above. Twenty five (17%) in the age group of 15-19 years strongly agreed that abstinence is not difficult to practice, 29 (19%) agreed with the statement which was also the number that disagreed 29 (19%). Twenty (14%) strongly disagreed and 47 (31%) were not sure.

The number of respondents in the age group 20-25 years who strongly agreed that abstinence is not difficult to practice was 23 (25%), 16 (18%) agreed, 31 (34%) disagreed, 5 (6%) strongly disagreed and 16 (17%) were not sure.

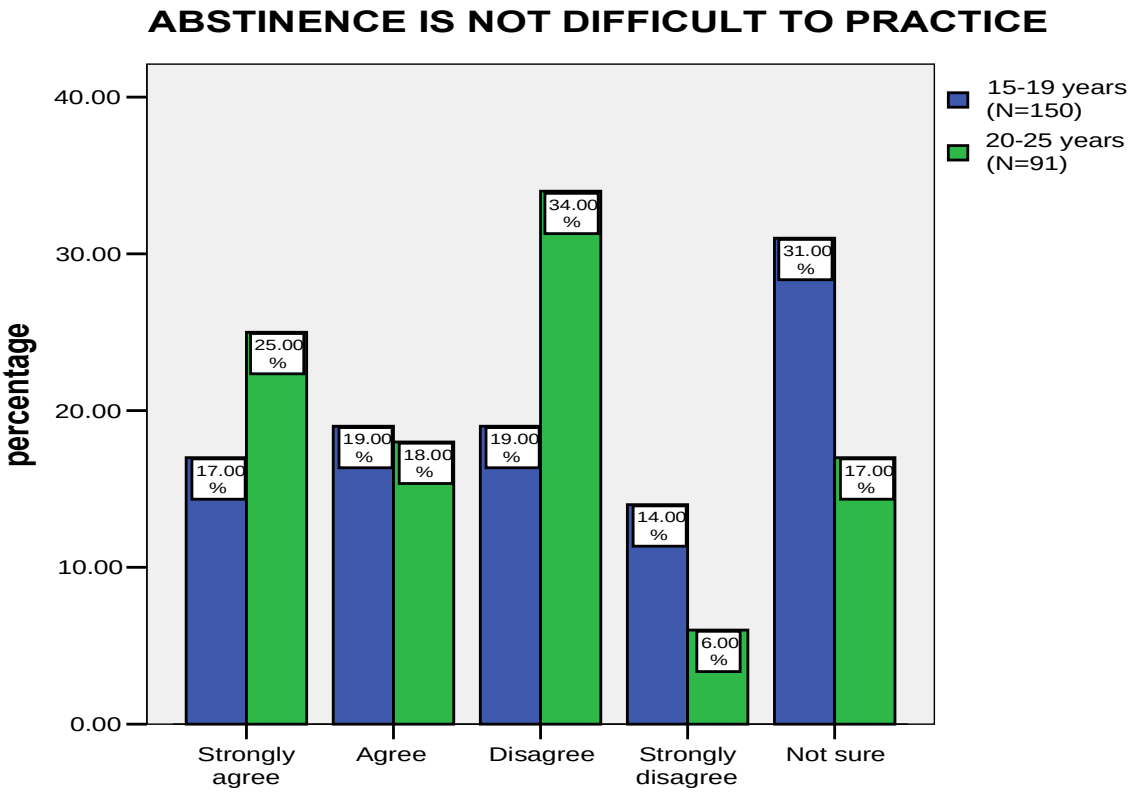

Figure 4.12

Abstinence not being difficult to practice by age group

Table 4.14: t-test result for abstinence not being difficult to practice by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	4.56	10.2
20-25 yrs	5	18.2	4.31	9.6
Mean difference	11.8			
95% CI	-2.7	To 26.3		
SE	6.27			
t statistic	1.88			
DF	8.0			
2-tailed p	0.0967			

There was no significant difference between the two age groups at 0.05 level (0.0967 >0.05 table 4.14).

4.3.3.2.2 It is not compulsory to be engaged in sexual activities

As shown in figure 4.13, 68 (45%) of age group 15-19 years strongly agreed, 31 (21%) agreed, 19 (13%) disagreed, 11 (7%) strongly disagreed and 21 (14%) were not sure that it is not compulsory to be engaged in sexual activity.

The young people aged 20-25 years that strongly agreed were 26 (29%), 32 (35%) agreed, 19 (21%) disagreed, 4 (4%) strongly disagreed while 10 (11%) were not sure that engaging in sexual activities is not compulsory.

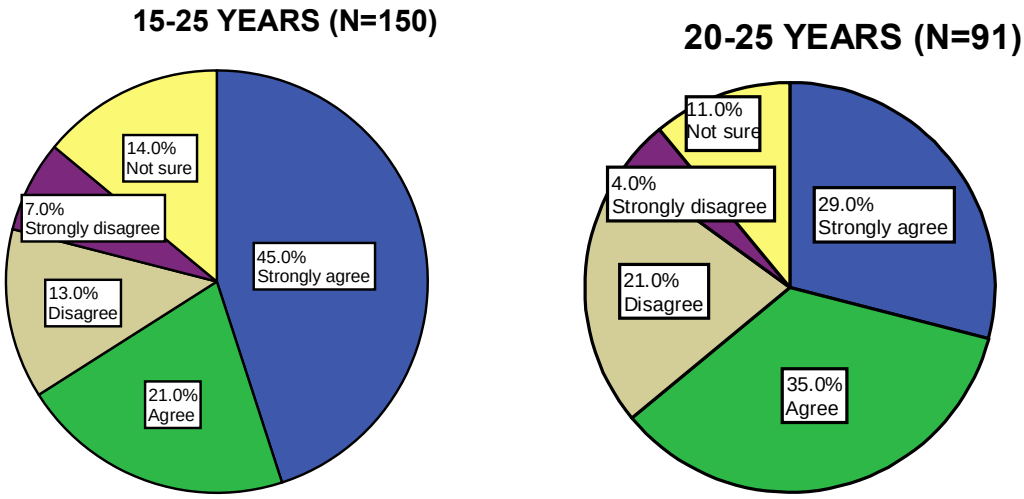

Figure 4.13

Sexual activities not being compulsory to be engaged into by age group

Table 4.15: t-test result for sexual activities not being compulsory to be engaged into by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	10.02	22.4
20-25 yrs	5	18.2	5.10	11.4
Mean difference	11.8			
95% CI	-14.1	to 37.7		
SE	11.24			
t statistic	1.05			
DF	8.0			
2-tailed p	0.3247			

From table 4.15, the *p-value* > 0.05 so the difference between the two age group was not statistically significant.

4.3.3.2.3 I feel comfortable talking about abstinence

Of the age group 15-19, 69 (46%) strongly agreed, 54 (36%) agreed, 27 (18%) disagreed whereas no respondent strongly disagreed or were not sure that they feel comfortable talking about abstinence.

In 20-25 years age group, 31 (34%) strongly agreed and 37 (41%) agreed that they feel comfortable talking about abstinence while none of the respondents disagreed or strongly disagreed, 23 (25%) were not sure (see Figure 4.14 below).

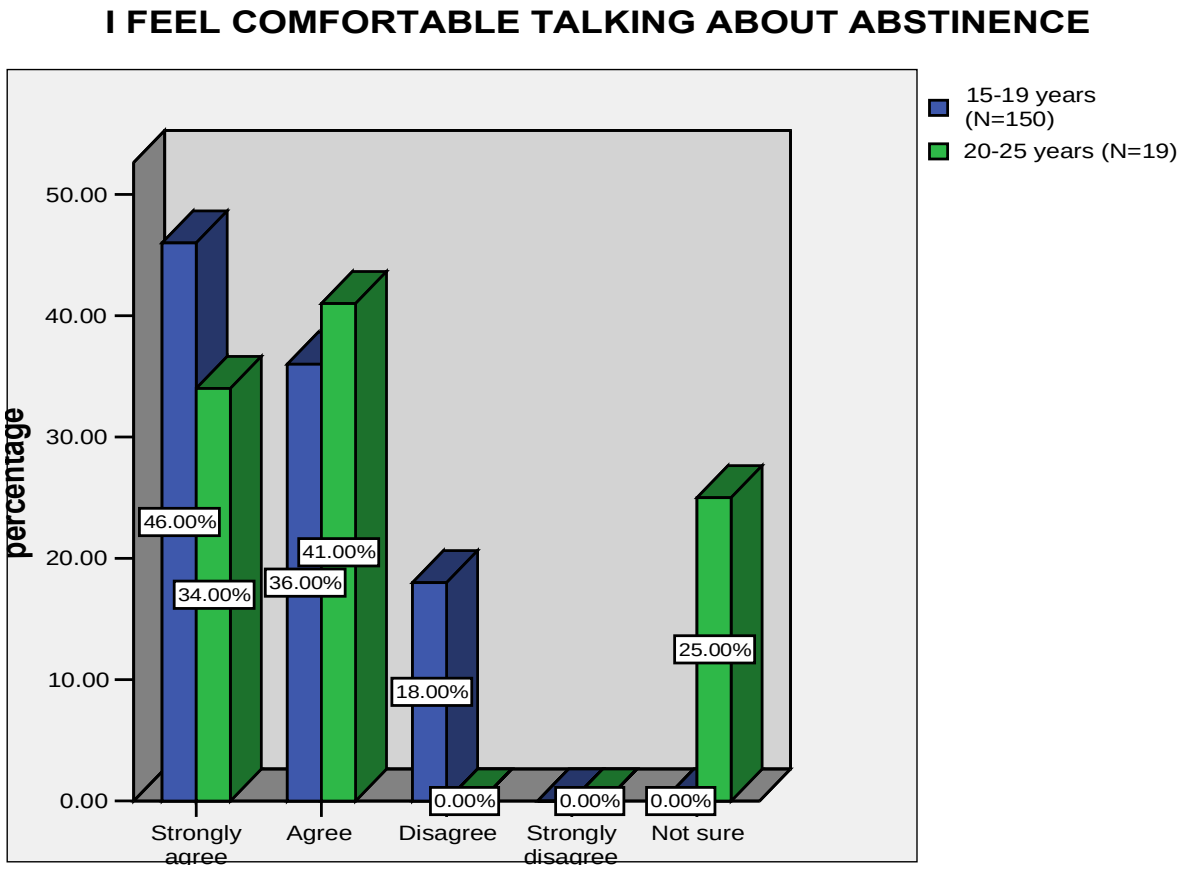

Figure 4.14

Talking comfortably about abstinence by age group

Table 4.16: t-test result for talking comfortably about abstinence by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	13.97	31.2
20-25 yrs	5	18.2	7.75	17.3
Mean difference	11.8			
95% CI	-25.1	to 48.7		
SE	15.98			
t statistic	0.74			
DF	8.0			
2-tailed p	0.4814			

The difference between the two age groups was not statistically significant (0.4814 >0.05 table 4.16).

4.3.3.2.4 Abstinence needs discipline and will power

Majority of the respondents 50 (55%) in 20-25 years age group strongly agreed that abstinence needs discipline and will power while the rest 41 (45%) agreed with the statement whereas in age group 15-19, 80 (53%) majority strongly agreed, 45 (30%) agreed while (17%) disagreed with the statement (See figure 4.15 below).

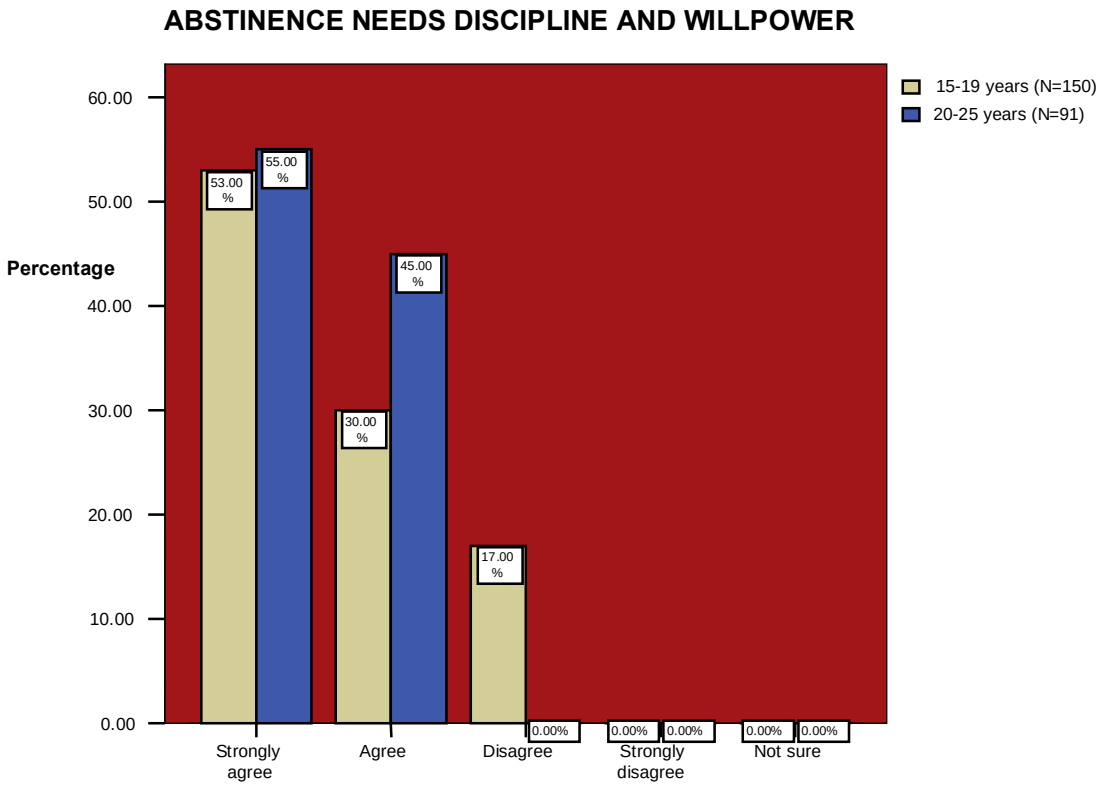

Figure 4.15

Abstinence needing discipline and willpower by age group

Table 4.17: t-test result for abstinence needing discipline and willpower by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	15.08	33.7
20-25 yrs	5	18.2	11.24	25.1
Mean difference	11.8			
95% CI	-31.6	to 55.2		
SE	18.81			
t statistic	0.63			
DF	8.0			
2-tailed p	0.5479			

There was no statistical significant difference between the two age groups (0.5479 >0.05 table 4.17).

4.3.3.2.5 Sexual intercourse is not the only way two people can get to know each other

Figure 4.16 shows the responses of the two age groups about the stated item above. Of the age group 15-19, 111 (74%) strongly agreed that sexual intercourse is not the only way two people can get to know each other, 36 (24%) agreed, 3 (2) disagreed. No respondent strongly disagreed or were not sure in the two age groups.

In age group 20-25 years, 45 (49%) strongly agreed, 36 (40%) agreed and 10 (11%) disagreed that sexual intercourse is not the only way two people can get to know each other.

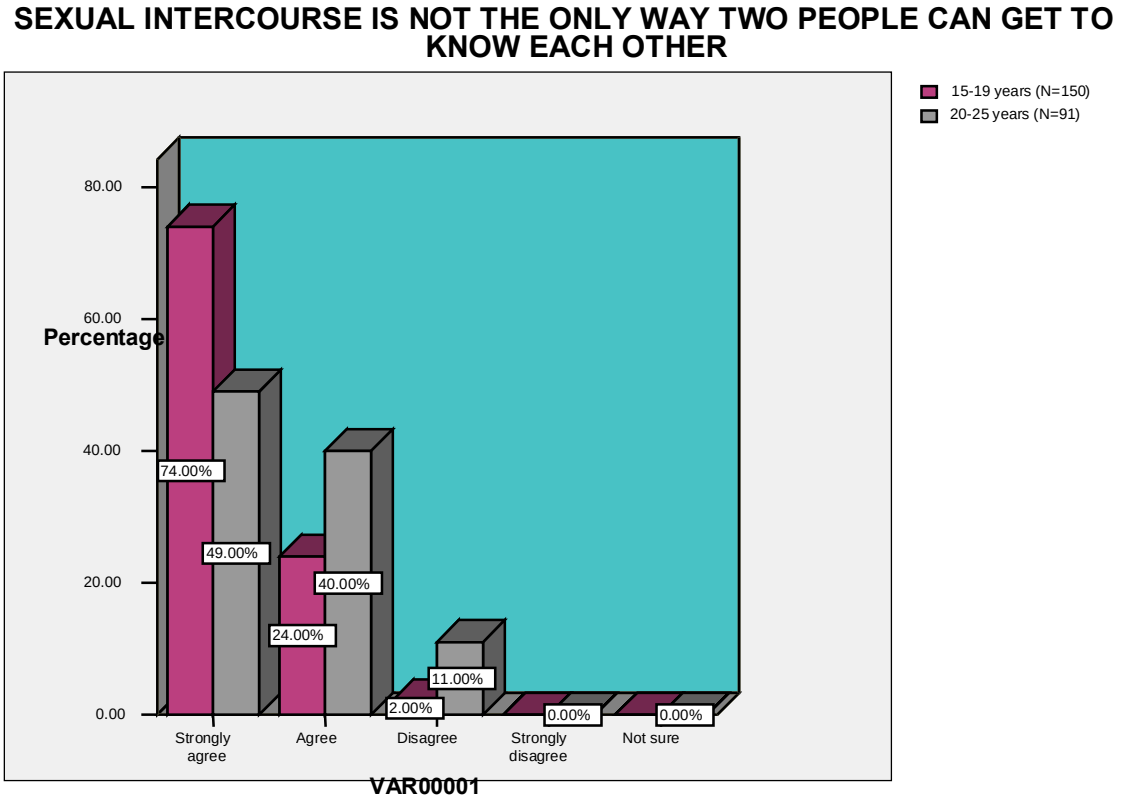

Figure 4.16

Sexual intercourse not being the only way to know each other by age group

Table 4.18: t-test result for sexual intercourse not the only way by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	21.36	47.8
20-25 yrs	5	18.2	9.39	21.0
Mean difference	11.8			
95% CI	-42.0	to 65.6		
SE	23.34			
t statistic	0.51			
DF	8.0			
2-tailed p	0.6267			

There was no statistical significant difference between the two age groups (0.6267>0.05 table 4.18).

4.3.3.2.6 Before engaging in sexual relation, one should think about it carefully

Among the young people aged 15-19 years, 96 (64%) strongly agreed that one should think carefully before engaging into sexual relation, 53 (35%) agreed with the statement. None of the respondents strongly disagreed or disagreed but only 1 (1%) was not sure.

Forty seven (52%) of young people aged 20-25 years strongly agreed that one should think about sexual relations carefully before engaging into it. Thirty six (40%) agreed, 5 (5%) disagreed, 0 (0%) strongly disagreed while 3 (3%) were not sure about it (refer to figure 4.17 below).

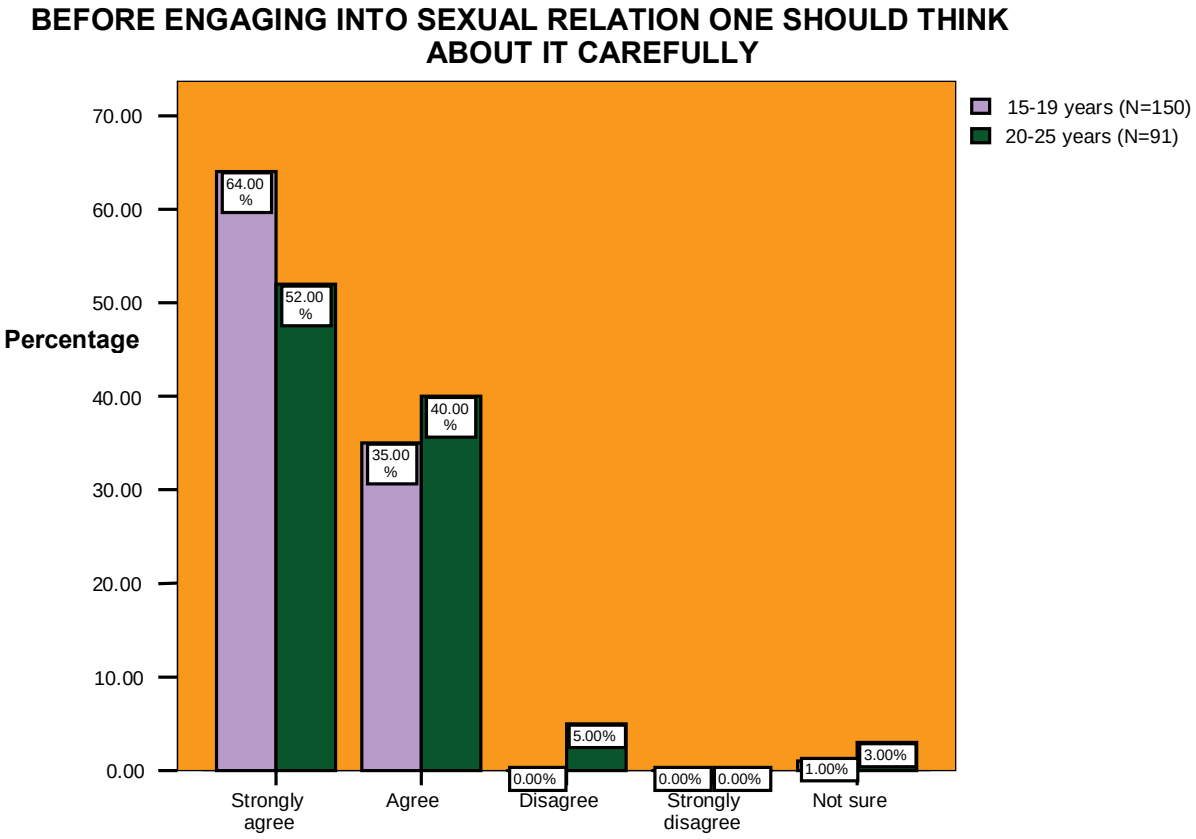

Figure 4.17

Thinking carefully before engaging into sexual intercourse by age group

Table 4.19: t-test result for thinking carefully before engaging into sexual intercourse by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	19.40	43.4
20-25 yrs	5	18.2	9.70	21.7
Mean difference	11.8			
95% CI	-38.2	to 61.8		
SE	21.69			
t statistic	0.54			
DF	8.0			
2-tailed p	0.6012			

There was no statistical significant difference between the two age groups (0.6012>0.05 table 4.19).

4.3.3.2.7 It is possible to postpone sexual relations until a person is able to take responsibility for his or her action

Twenty five (17%) strongly agreed, 19 (13%) agreed, 64 (42%) disagreed 39 (26%) strongly disagreed and 3 (2%) of the respondents were not sure in the age group 15-19 that it is possible to postpone sexual relations until a person is able to take responsibility for his or her action while in age group 20-25, 2 (2%) strongly agreed, 24 (26%) agreed, 27 (30%) disagreed, 18 (20%) strongly disagreed and 20 (22%) were not sure with the statement (refer to figure 4.18).

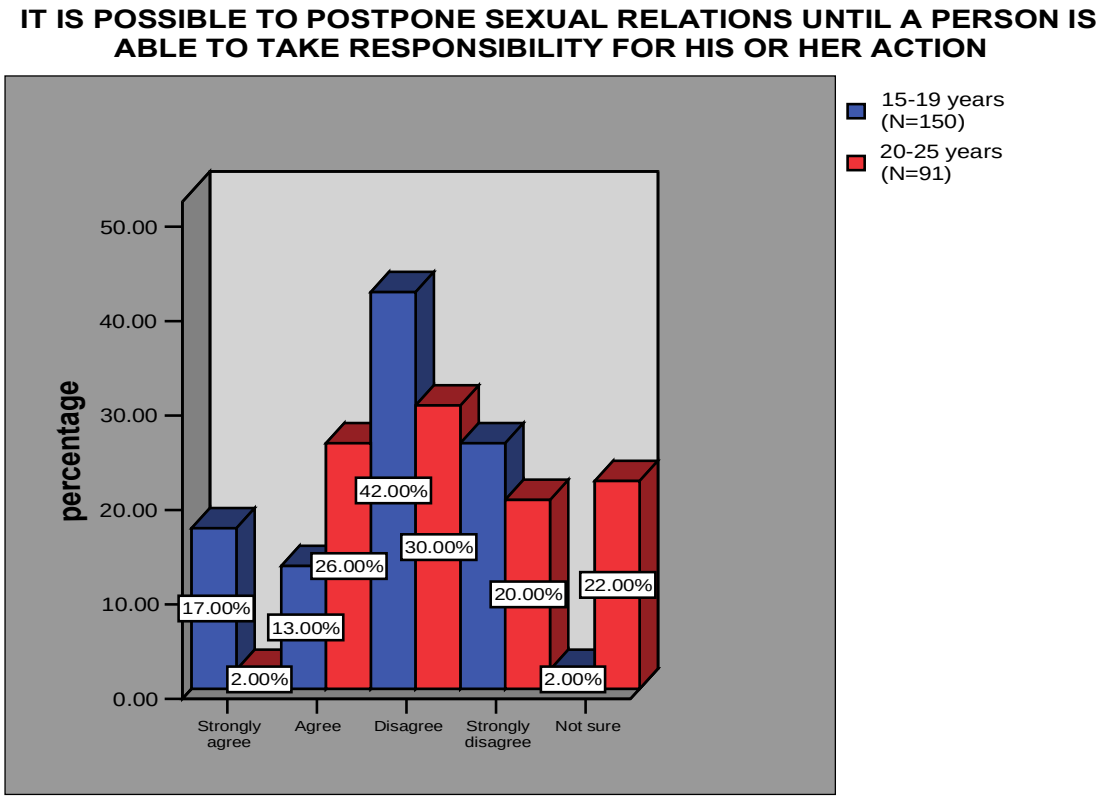

Figure 4.18

Postponing sexual relations by age group

Table 4.20: t-test result for postponing sexual relations by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	10.28	23.0
20-25 yrs	5	18.2	4.34	9.7
Mean difference	11.8			
95% CI	-13.9	to 37.5		
SE	11.16			
t statistic	1.06			
DF	8.0			
2-tailed p	0.3210			

There was no statistical significant difference between the two age groups (0.3210>0.05 table 4.20).

4.3.3.2.8 If I love my partner I will not prove my love for him /her by having sex with him/her

In figure 4.19, 40 (26%) strongly agreed,12 (8%) agreed, 10(7%) disagreed, 7 (5%) strongly disagreed and 81(54%) were not sure to the stated item above in age group 15-19 years.

Of the age group 20-25, 5 (6%) strongly agreed, 30 (32%) agreed, 5 (6%) disagreed, 7 (8%) strongly disagreed and 44 (48%) were not sure to the stated item above.

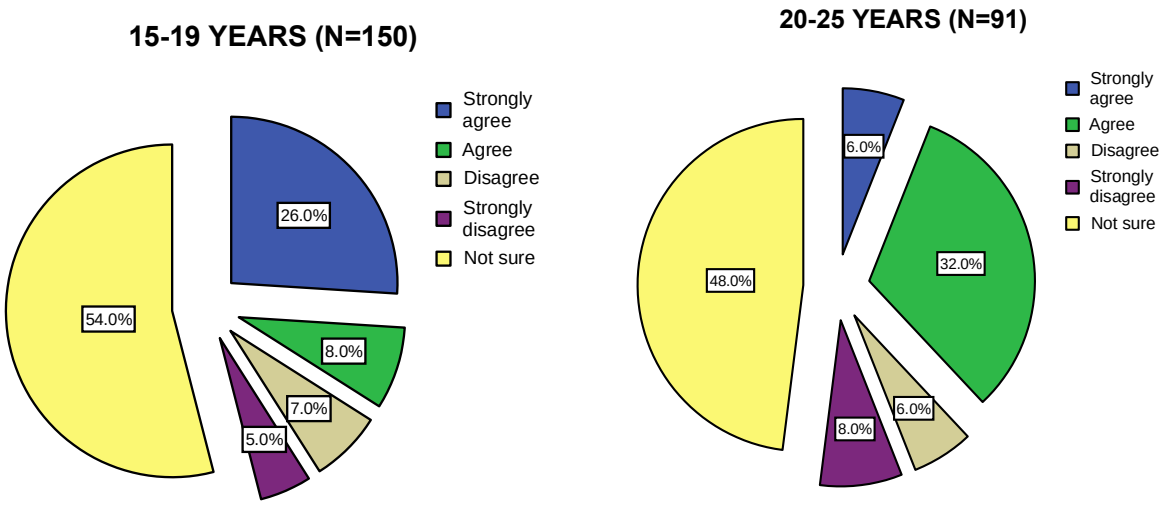

Figure 4.19

Proof of love by age group

Table 4.21: t-test result for proof of love by age group

n	10			
Groups	n	Mean	SE	SD
15-19 yrs	5	30.0	14.06	31.4
20-25 yrs	5	18.2	8.00	17.9
Mean difference	11.8			
95% CI	-25.5	to 49.1		
SE	16.18			
t statistic	0.73			
DF	8.0			
2-tailed p	0.4865			

There was no statistical significant difference between the two age groups (0.4865>0.05 table 4.21).

4.3.3.3 Attitude towards being faithful by gender

Section C of the questionnaire consisted of seven items which collected information about respondentsôattitude towards being faithful. Like in Section B, it was done according to age categories of 15-19 and 20-25 and gender in order to show comparison of attitudes between the two age groups and between males and females. This is in line with the objectives of the study.

4.3.3.3.1 Faithfulness is very important in a relationship

The percentage of females that strongly agreed was 82 (57%), 63 (43%) agreed. There was 44 (46%) males that strongly agreed and 52 (54%) that agreed .

There was no statistical significant difference between the male and female group (t= -0.45, df=8 and *p*= 0.6613>0.05).

4.3.3.3.2 It is possible to contract HIV/AIDS from a regular partner

Figure 4.20 presents the responses by gender to the item stated above.

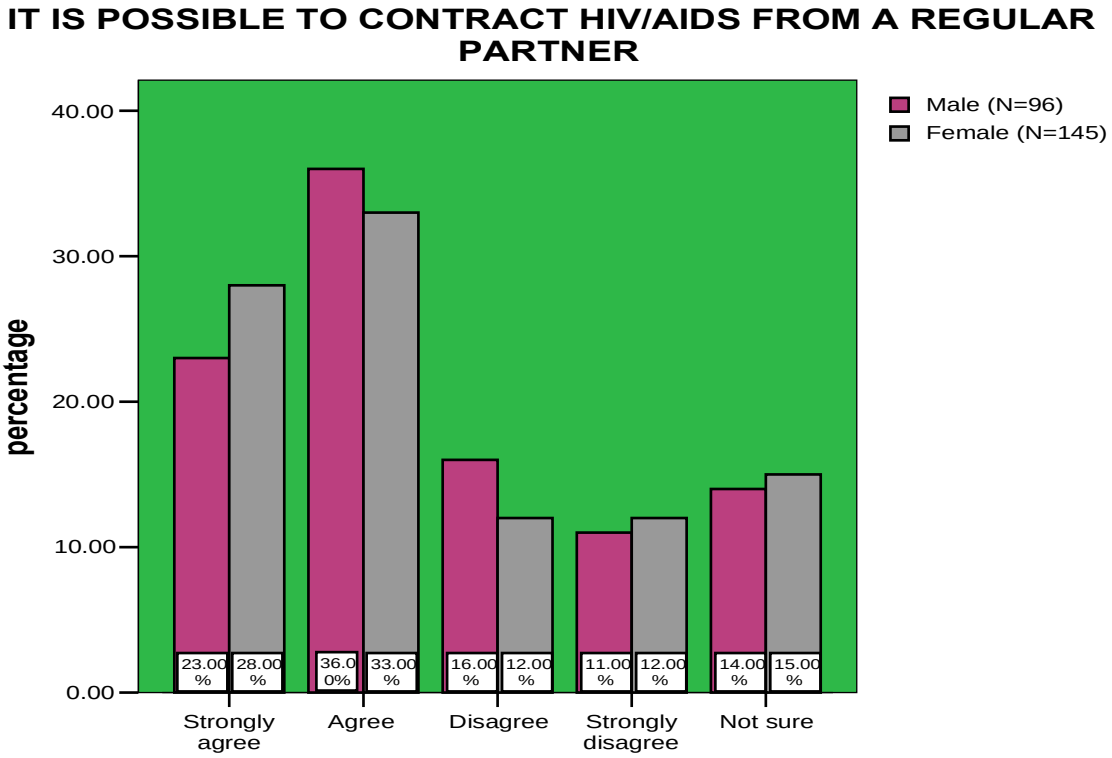

Figure 4.20

Contracting HIV/AIDS from regular partner by gender

Fourty (28%) female respondents strongly agreed to 22 (23%) male respondents who strongly agreed that it is possible to contract HIV/AIDS from a regular partner. Thirty five (36%) male respondents agreed to 48 (33%) female respondents who agreed. Fifteen (16%) males disagreed to 18 (12%) females that disagreed. Eleven (11%) males strongly disagreed to 17 (12%) females that strongly disagreed and finally 13 (14%) males were not sure to 22 (15%) that were not sure to the stated item above.

Table 4.22: t-test result for contracting HIV/AIDS from regular partner by gender

n	10			
Groups	N	Mean	SE	SD
Males	5	19.2	4.36	9.8
Females	5	29.0	6.31	14.1
Mean difference	-9.8			
95% CI	-27.5	to 7.9		
SE	7.67			
t statistic	-1.28			
DF	8.0			
2-tailed p	0.2372			

There was no statistical significant difference between the male and female group (0.2372>0.05 table 4.22).

4.3.3.3.3 If a person finds out that he or she has HIV/AIDS, he or she has to talk about it with his or her partner

See figure 4.21 for the responses of males and females to the stated item above.

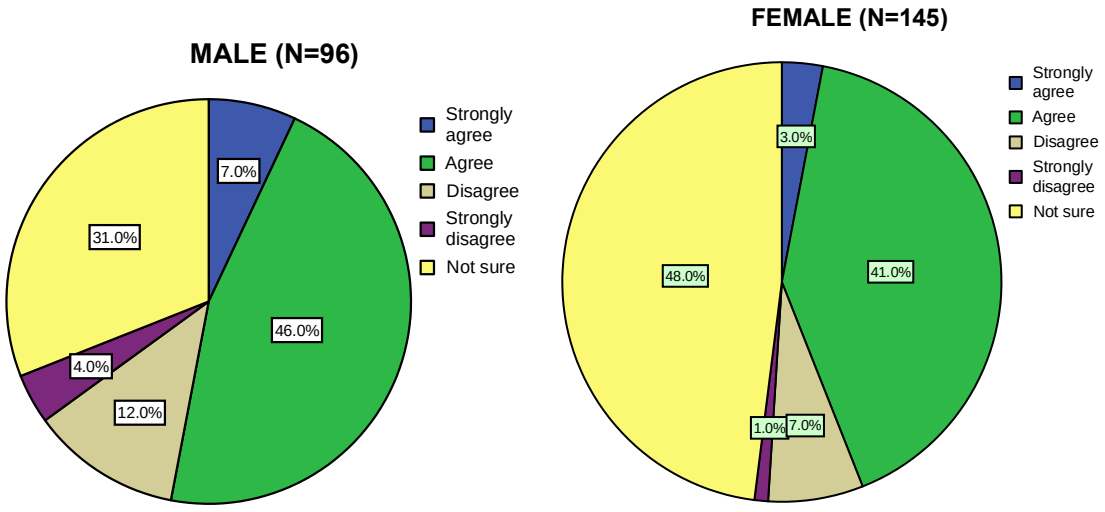

Figure 4.21

Letting partners know about positive HIV/AIDS status by gender

Seven (7%) males strongly agreed, 44 (46%) agreed, 11 (12%) disagreed, 4 (4%) strongly disagreed while 30 (31%) were not sure if a person finds out that he or she has HIV/AIDS if he or she has to talk about it with his or her partner.

In the female group, 5 (3%) strongly agreed, 59 (41%) agreed, 10 (7%) disagreed, 2 (1%) strongly disagreed while 69 (48%) were not sure to the stated item above.

Table 4.23: t-test result for letting partners know about positive HIV/AIDS status by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	7.68	17.2
Females	5	29.0	14.43	32.3
Mean difference	-9.8			
95% CI	-47.5	to 27.9		
SE	16.35			
t statistic	-0.60			
DF	8.0			
2-tailed p	0.5654			

There was no statistical significant difference between the male and female group (0.5654>0.05 table 4.23).

4.3.3.3.4 It is important that one can talk with his or her partner about HIV/AIDS

The male respondents were 49 (51%) that strongly agreed while 47 (49%) agreed that it is important that one talk with his or her partner about HIV/AIDS. Females that strongly agreed were 61 (42%) and 82 (57%) agreed. None of the respondent in both groups disagreed or strongly disagreed or were not sure with the statement.

There was no statistical significant difference between the male and female group (t= -0.46, df=8, p=0.6566>0.05).

4.3.3.3.5 Only the two people who trust each other completely should have sexual relations

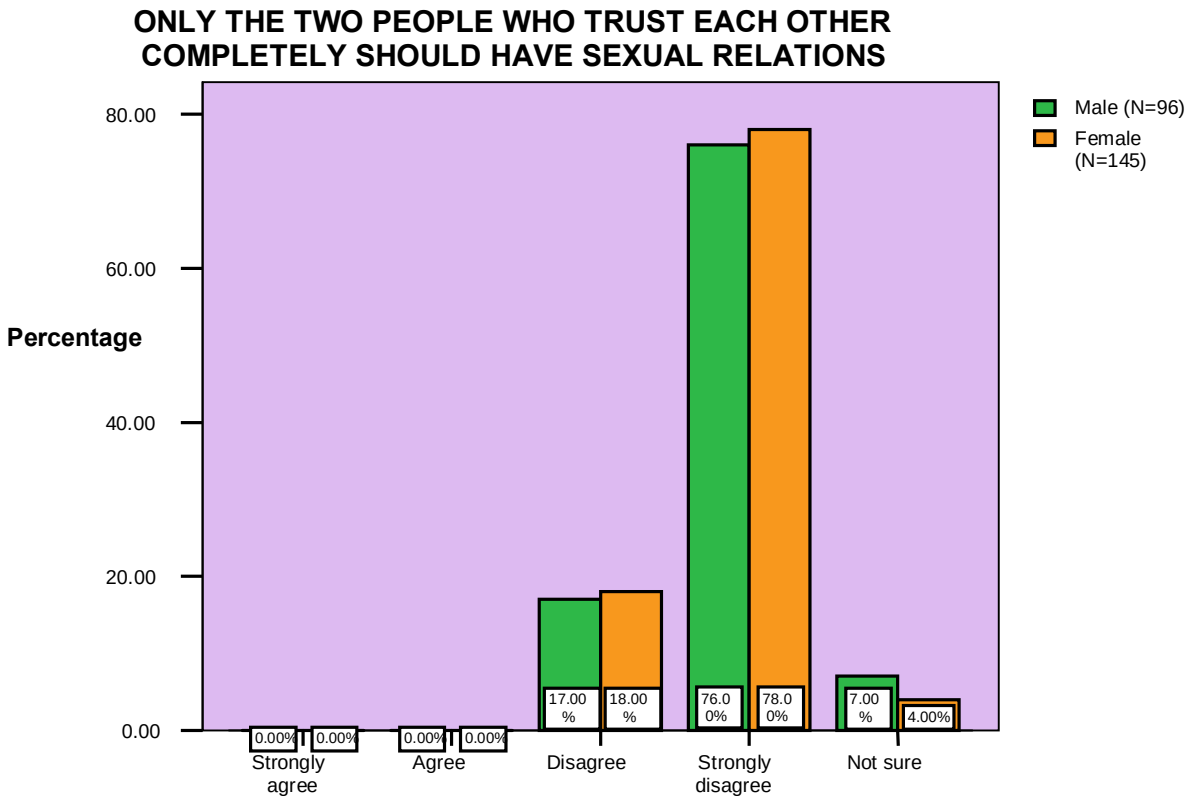

Figure 4.22

Sexual relations meant only for two trusted people by gender

Sixteen (17%) males disagreed, 73 (76%) strongly disagreed, 7 (7%) were not sure while 26 (18%) females disagreed, 113 (78%) strongly disagreed and 6 (4%) were not sure that only two people who trust each other completely should have sexual relations (figure 4.22 above).

Table 4.24: t-test result for sexual relations meant only for trusted people by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	13.77	30.8
Females	5	29.0	21.54	48.2
Mean difference	-9.8			
95% CI	-68.7	to 49.1		
SE	25.56			
t statistic	-0.38			
DF	8.0			
2-tailed p	0.7114			

There was no statistical significant difference between the male and female group (0.7114>0.05 table 4.24).

4.3.3.3.6 It is boring to have the same sexual partner for a long time

Figure 4.23 shows the percentage responses of males and females to the stated item above.

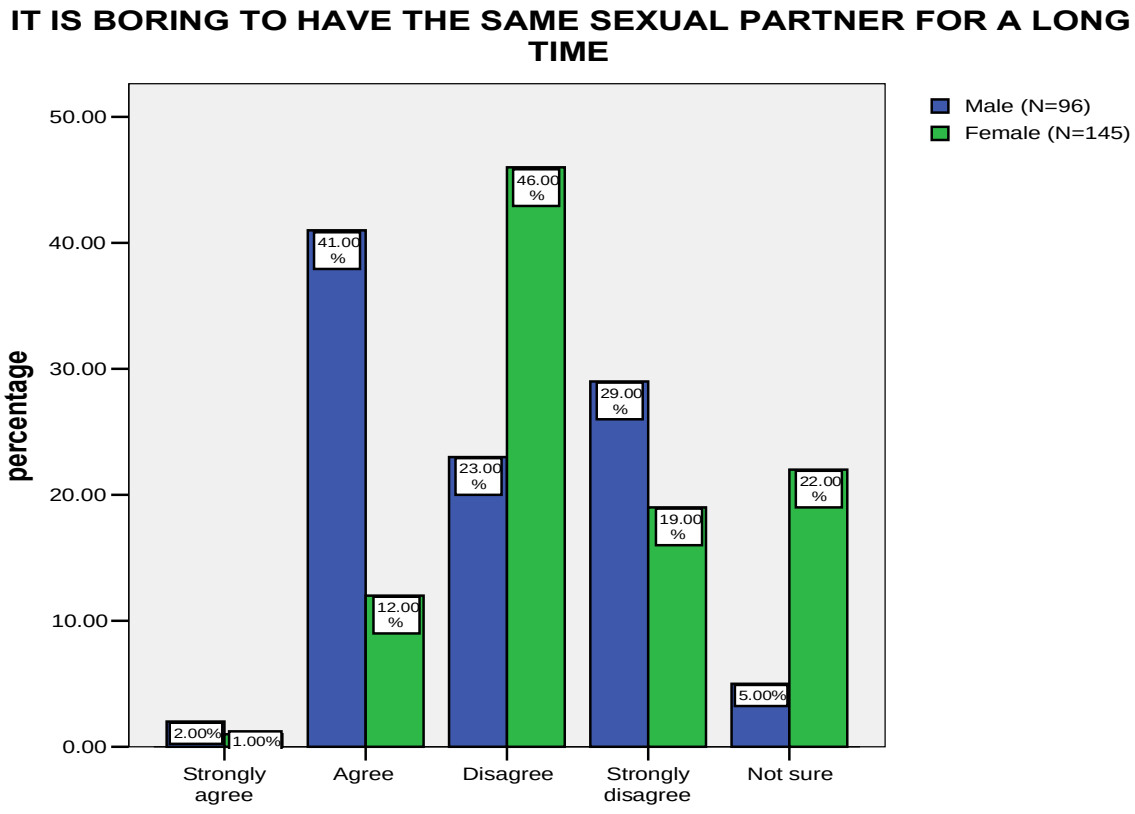

Figure 4.23

Long time partner being boring by gender

Two (2%) males strongly agreed, 39 (41%) agreed, 22 (23%) disagreed, 28 (29%) strongly disagreed that it is boring having same sexual partner for a long time and 20 (22%) were not sure while 2 (1%) females strongly agreed, 17 (12%) agreed, 67 (46%) disagreed, 28 (19%) strongly disagreed and 31 (22%) were not sure to the stated item above.

Table 4.25: t-test result for long time partner being boring by gender

n	10			
Groups	N	Mean	SE	SD
Males	5	19.2	6.98	15.6
Females	5	29.0	10.77	24.1
Mean difference	-9.8			
95% CI	-39.4	to 19.8		
SE	12.84			
t statistic	-0.76			
DF	8.0			
2-tailed p	0.4672			

There was no statistical significant difference between the male and female group (0.4672>0.05 table 4.25).

4.3.3.3.7 Having sex with many people does not make sex more enjoyable

Figure 4.24 below shows the responses by gender to the stated item above.

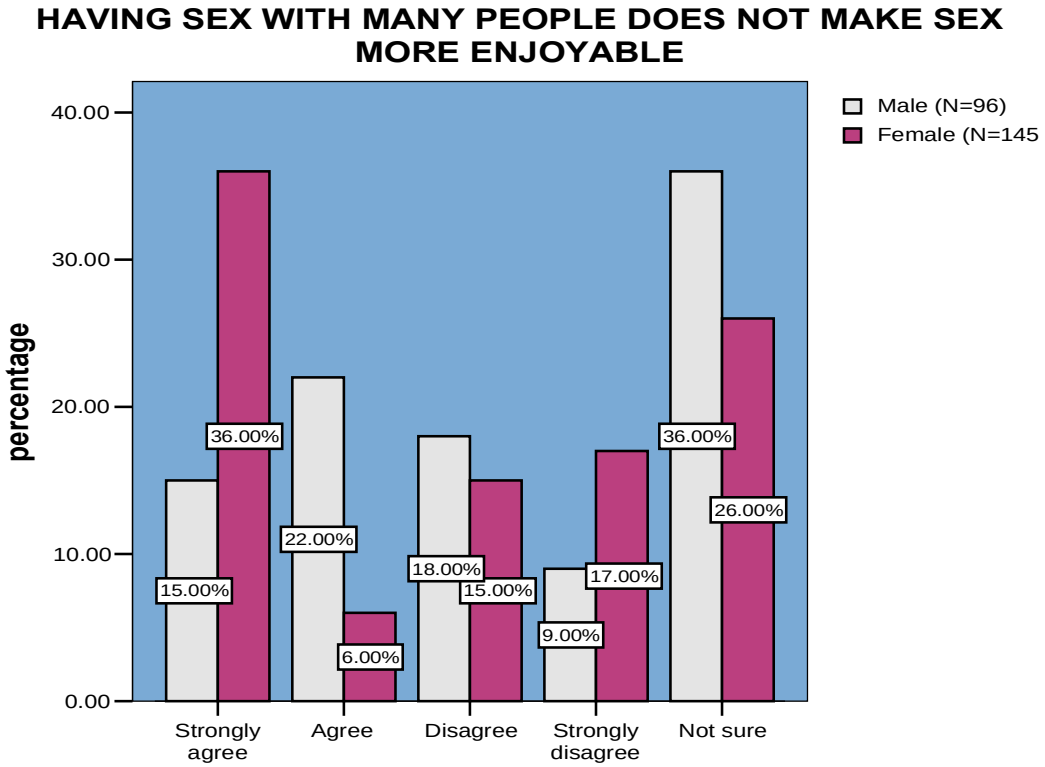

Figure 4.24

Sex not enjoyable with many people by gender

Fourteen (15%) males strongly agreed, 21 (22%) agreed, 17 (18%) disagreed, 9 (9%) strongly disagreed and 3 (3%) were not sure that having sex with many people does not make sex more enjoyable. Fifty two (36%) females strongly agreed, 9 (6%) agreed, 21 (15%) disagreed, 25 (17%) strongly disagreed and 38 (26%) were not sure to the stated item above.

Table 4.26: t-test result for sex not enjoyable with many people by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	4.41	9.9
Females	5	29.0	7.38	16.5
Mean difference	-9.8			
95% CI	-29.6	to 10.0		
SE	8.60			
t statistic	-1.14			
DF	8.0			
2-tailed p	0.2874			

There was no statistical significant difference between the male and female group (0.2874>0.05 table 4.26).

4.3.3.4 Attitude towards being faithful by age group

4.3.3.4.1 Faithfulness is very important in a relationship

Eighty two (55%) strongly agreed that faithfulness is very important in a relationship while 68 (45%) agreed with the statement. None of the respondents disagreed, strongly disagreed or were not sure.

Table 4.27: t-test result for importance of faithfulness in a relationship by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	18.50	41.4
20-25 Yrs	5	18.2	11.72	26.2
Mean difference	11.8			
95% CI	-38.7	to 62.3		
SE	21.91			
t statistic	0.54			
DF	8.0			
2-tailed p	0.6048			

There was no statistical significant difference between the two age groups (0.6048>0.05 table 4.27).

4.3.3.4.2 It is possible to contract HIV/AIDS from a regular partner

The highest respondents were 46 (31%) in age group 15-19 years that strongly agreed followed by 38 (25%) that agreed followed by 28 (18%) that strongly disagreed followed by 22 (15%) that were not sure then followed by 16 (11%) that disagreed that it is possible to contract HIV/AIDS from a regular partner (see figure 4.25 below).

Age group 20-25 had 45 (49%) as the highest percentage followed by 17 (19%) that disagreed followed by 16 (18%) that strongly agreed followed by 13 (14%) that were not sure then no respondent strongly disagree to the above stated item ñ*It is possible to contract HIV/AIDS from a regular partner"* (Figure 4.25).

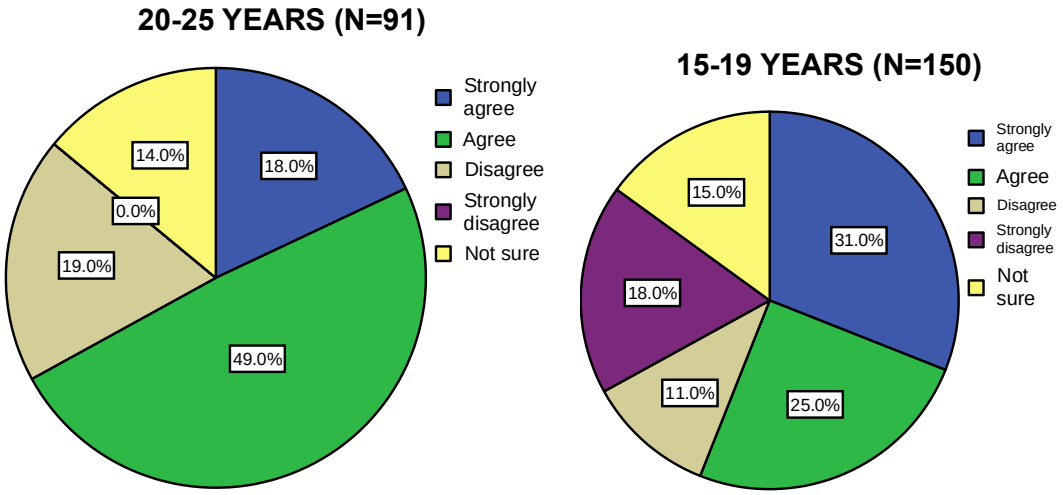

Figure 4.25

Contracting HIV/AIDS from regular partner by age group

Table 4.28: t-test result for contracting HIV/AIDS from regular partner by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	5.40	12.1
20-25 Yrs	5	18.2	7.36	16.5
Mean difference	11.8			
95% CI	-9.3	to 32.9		
SE	9.13			
t statistic	1.29			
DF	8.0			
2-tailed p	0.2322			

There was no statistical significant difference between the two age groups (0.2322>0.05 table 4.28).

4.3.3.4.3 If a person finds out that he or she has HIV/AIDS, he or she has to talk about it with his or her partner

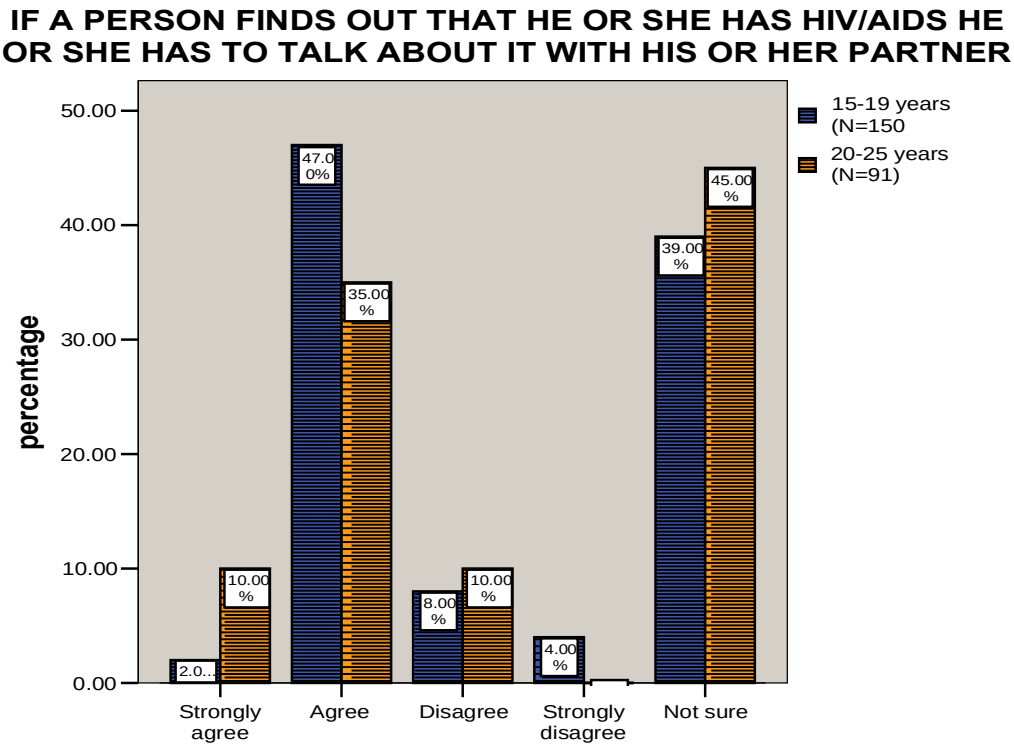

Figure 4.26

Letting partners know about positive HIV/AIDS status by age group

Figure 4.26 shows that 71 (47%), being the highest percentage of respondents in age group 15-19 years agreed that if a person finds out that he or she has HIV/AIDS he or she has to talk about it with his or her partner whereas the highest percentage of respondents in age group 20-25 years was 41 (45%) who were not sure about it. Three (2%) of age group 15-25 years strongly agreed, 12 (8%) disagreed, 6 (4%) strongly disagreed while 58 (39%) were not sure. In age group 20-25, 9 (10%) strongly agreed, 32 (35%) agreed, 9 (10%) disagreed while no respondent strongly disagreed.

Table 4.29: t-test result for letting partners know about positive HIV/AIDS status by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	14.31	32.0
20-25 Yrs	5	18.2	7.78	17.4
Mean difference	11.8			
95% CI	-25.8	to 49.4		
SE	16.29			
t statistic	0.72			
DF	8.0			
2-tailed p	0.4894			

There was no statistical significant difference between the two age groups (0.4894>0.05 table 4.29).

4.3.3.4.4 It is important that one can talk with his or her partner about HIV/AIDS

Eighty one (54%) respondent in age group 15-19 strongly agreed, 67 (45%) agreed while 2 (1%) was not sure if it is important that one talks with his or her partner about HIV/AIDS. None of the respondents disagreed or strongly disagreed to the stated item above.

Age group 20-25 had 29 (32%) that strongly agreed while 62 (68%) agreed. None disagreed, strongly disagreed or were not sure. In the male group, 49 (51%) strongly agreed, 47 (49%) agreed while none of the respondents disagreed, strongly disagreed or were not sure to the stated item above.

Table 4.30: t-test result for talking over HIV/AIDS with partner by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	18.10	40.5
20-25 Yrs	5	18.2	12.31	27.5
Mean difference	11.8			
95% CI	-38.7	to 62.3		
SE	21.89			
t statistic	0.54			
DF	8.0			
2-tailed p	0.6045			

There was no statistical significant difference between the two age groups (0.6045>0.05 table 4.30).

4.3.3.4.5 Only the two people who trust each other completely should have sexual relations

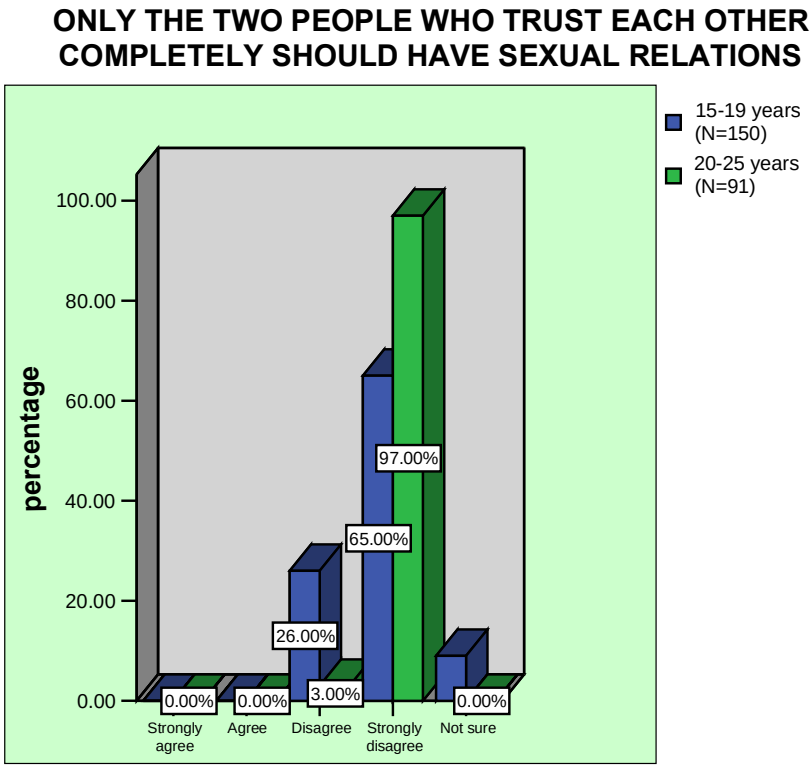

Figure 4.27

Sexual relations meant only for two trusted people by age group

Figure 4.27 above shows that in 20-25 years age group, 3 (3%) disagreed, 7 (7%) were not sure, 88 (97%) strongly disagreed and that only the two people who trust each other completely should have sexual relation while in 15-19 years age group 13 (9%) were not sure 39 (26%) strongly agreed and 98 (65%) strongly disagreed with the statement.

Table 4.31: t-test result for sexual relations meant only for two trusted people by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	18.43	41.2
20-25 Yrs	5	18.2	17.46	39.0
Mean difference	11.8			
95% CI	-46.7	to 70.3		
SE	25.39			
t statistic	0.46			
DF	8.0			
2-tailed p	0.6545			

There was no statistical significant difference between the two age groups (0.6545>0.05 table 4.31).

4.3.3.4.6 It is boring to have the same sexual partner for a long time

Figure 4.28 shows that none of the respondents strongly agreed, 12 (8%) agreed, 66 (44%) disagreed, 56 (37%) strongly disagreed and 16 (11%) were not sure in age group 15-19 years to the stated item above.

In age group 20-25, 4 (4%) strongly agreed, 44 (49%) agreed, 23 (25%) disagreed, 20 (22%) were not sure, none of the respondent strongly disagreed to the stated item above.

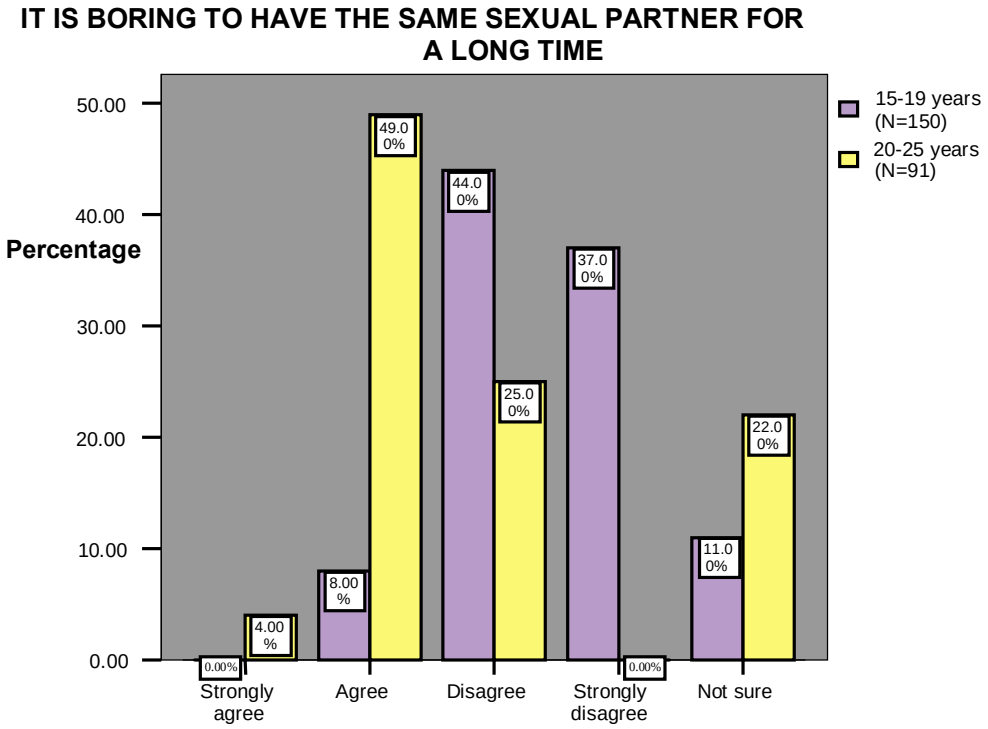

Figure 4.28

Long time partner being boring by age group

Table 4.32: t-test result for long time partner being boring by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	13.02	29.1
20-25 Yrs	5	18.2	7.83	17.5
Mean difference	11.8			
95% CI	-23.2	to 46.8		
SE	15.19			
t statistic	0.78			
DF	8.0			
2-tailed p	0.4597			

There was no statistical significant difference between the two age groups (0.4597>0.05 table 4.32).

4.3.3.4.7 Having sex with many people does not make sex more enjoyable

In Figure 4.29 below, 61 (41%) strongly agreed, 3 (2%) agreed, 16 (11%) disagreed, none of the respondent strongly disagreed and 70 (47%) were not sure in age group 15-19 to the stated item above.

Of the age group 20-25, 5 (6%) strongly agreed, 27 (30% agreed, 22 (24%) disagreed, 34 (37%) strongly disagreed while 3 (3%) were not sure to the stated item above.

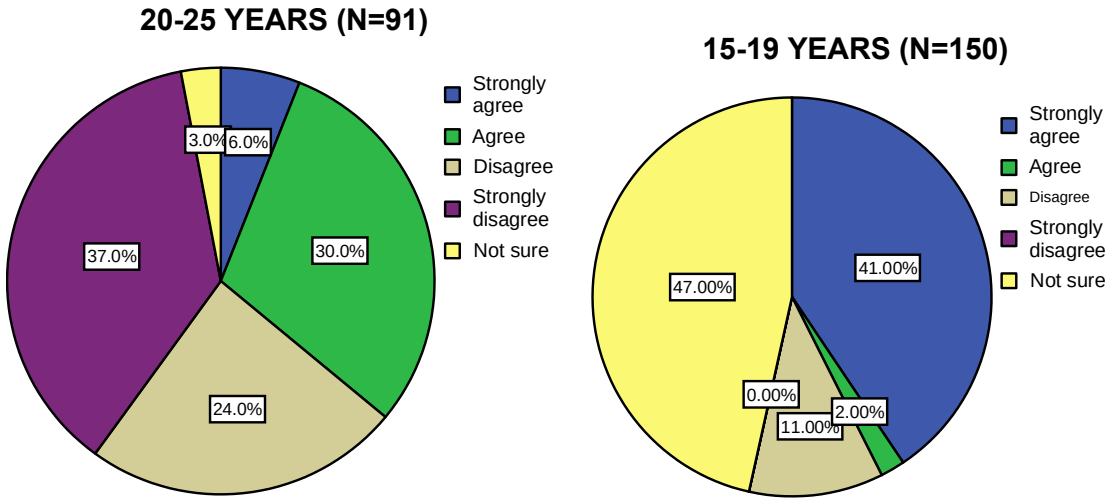

Figure 4.29

Sex not enjoyable with many people by age group

Table 4.33: t-test result for sex not enjoyable with many people by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	14.81	33.1
20-25 Yrs	5	18.2	6.11	13.7
Mean difference	11.8			
95% CI	-25.1	to 48.7		
SE	16.02			
t statistic	0.74			
DF	8.0			
2-tailed p	0.4824			

There was no statistical significant difference between the two age groups (0.4824>0.05 table 4.33).

4.3.3.5 Attitude towards condom by gender

Section D of the questionnaire consisted of 9 items which collected information about respondentsôattitude towards condom. The report on attitudes of young people towards condom was done according to gender in order to show comparison of attitudes between males and females. This is in line with the objectives of the study.

4.3.3.5.1 Using condom does not help to prevent HIV/AIDS

Figure 4.30 shows the responses of young people towards the stated item by gender.

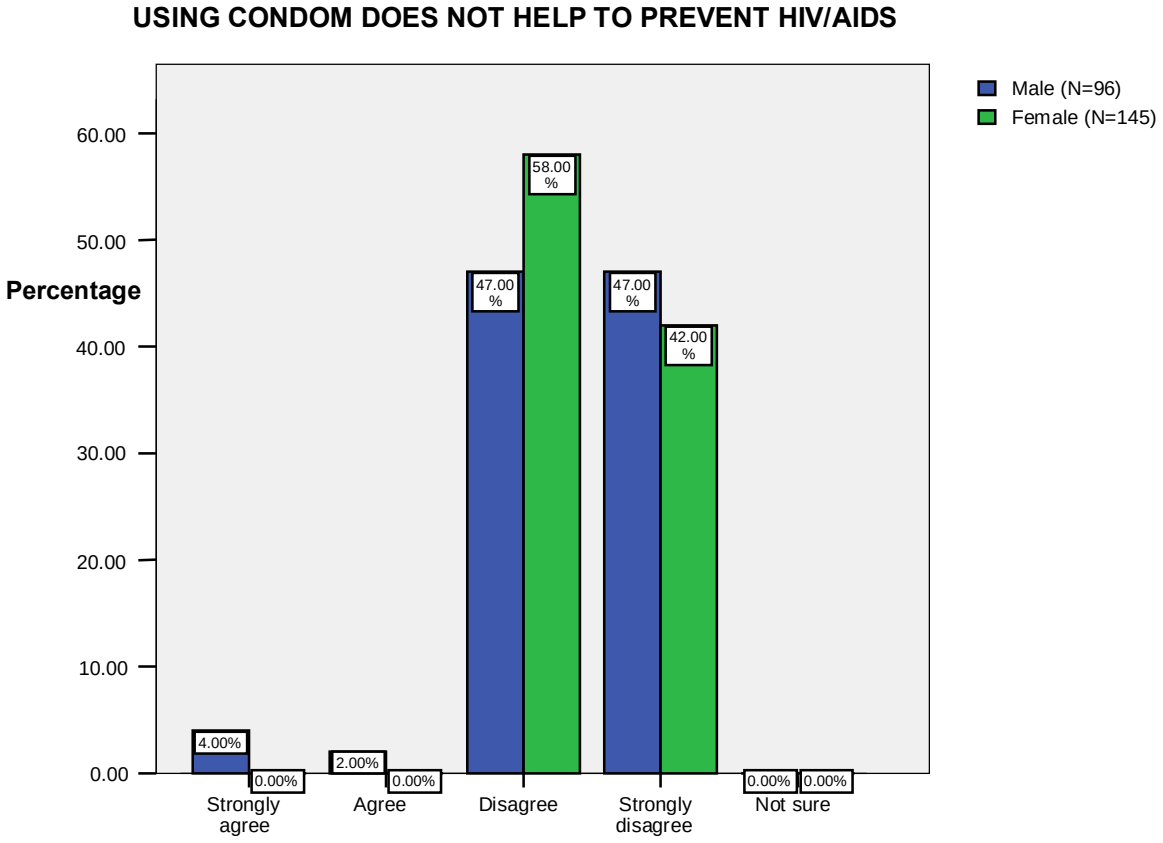

Figure 4.30

Condom helping to prevent HIV/AIDS by gender

Four (4%) males strongly agreed, 2 (2%) agreed, 45 (47%) disagreed, 45 (47%) strongly disagreed while none of the respondents were not sure that using condom does not help to prevent HIV/AIDS.

Eighty four (58%) females disagreed, 61 (42%) strongly disagree while none strongly agreed or were not sure to the item stated above.

Table 4.34: t-test result for condom helping to prevent HIV/AIDS by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	10.55	23.6
Females	5	29.0	18.13	40.5
Mean difference	-9.8			
95% CI	-58.2	to 38.6		
SE	20.97			
t statistic	-0.47			
DF	8.0			
2-tailed p	0.6528			

There was no statistical significant difference between the male and female groups (0.6528>0.05 table 4.34).

4.3.3.5.2 If I love my partner, I will prove my love for him/her by having sex with him/her without using a condom

Figure 4.31 presents the responses of young people to the stated item above by gender.

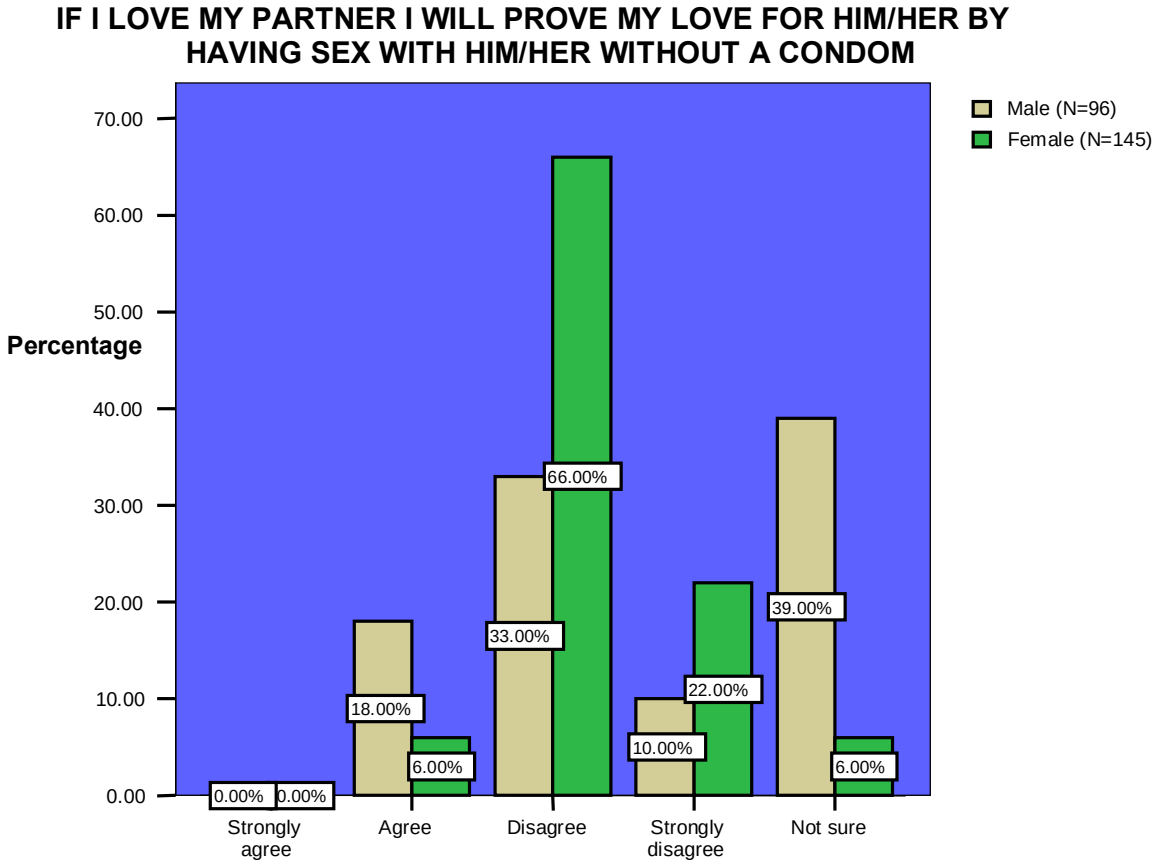

Figure 4.31

Proof of love by having sex without condom by gender

Thirty seven (39%) male respondents who were not sure if they love their partners if they will prove their love by having sex with them without a condom were higher than 8 (6%) female respondents while 96 (66%) females who disagreed and 33 (22%) females who strongly disagreed were higher than 32 (33%) males that disagreed and 10 (10%) that strongly disagreed. Seventeen (18%) males agreed to 8 (6%) females that agreed to the stated item above.

Table 4.35: t-test result for proof of love by having sex without a condom by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	6.85	15.3
Females	5	29.0	17.65	39.5
Mean difference	-9.8			
95% CI	-53.5	to 33.9		
SE	18.93			
t statistic	-0.52			
DF	8.0			
2-tailed p	0.6187			

There was no statistical significant difference between the male and female groups (0.6187>0.05 table 4.35).

4.3.3.5.3 Buying condom is embarrassing

Figure 4.32 shows responses by gender about buying condom being embarrassing.

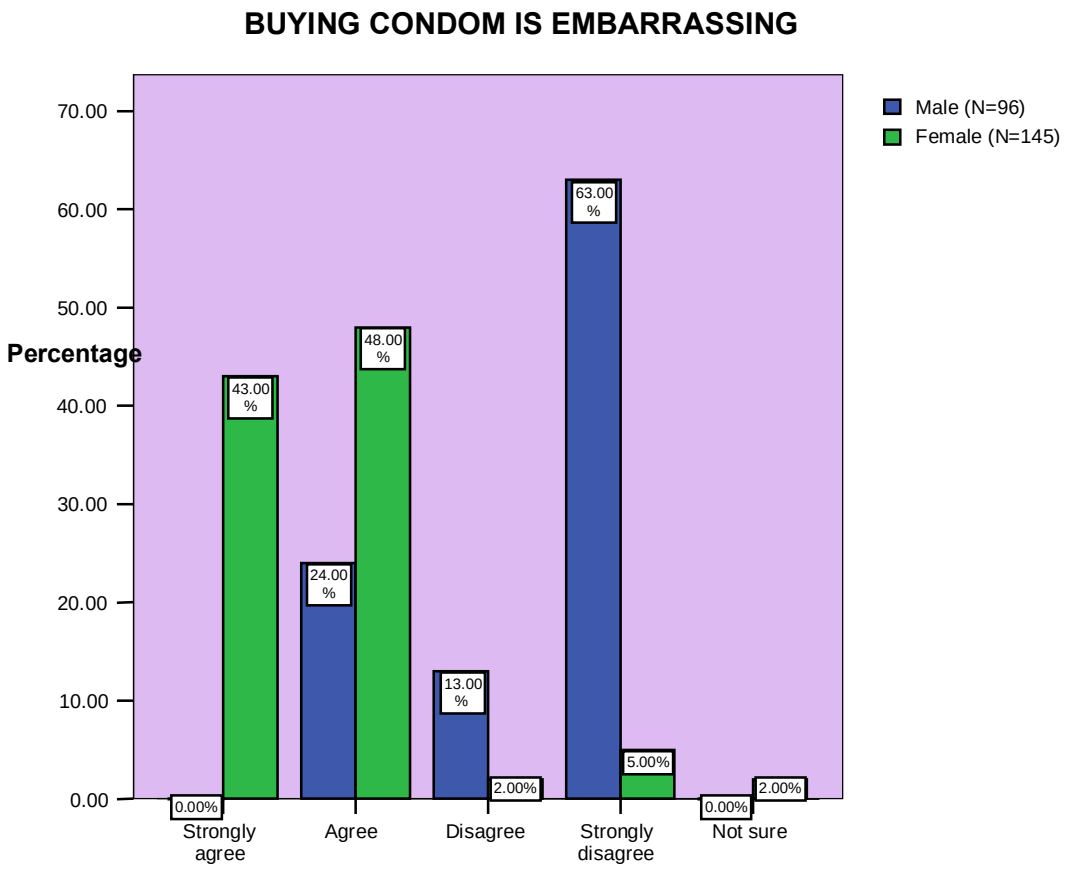

Figure 4.32

Buying condom being embarrassing by gender

None of the males strongly agreed or were not sure that buying condom is embarrassing, 23 (24%) agreed, 12 (13%) disagreed and 61 (63%) strongly disagreed while 62 (43%) females strongly agreed, 70 (48%) agreed, 3 (2%) disagreed, 7 (5%) strongly disagreed and 3 (2%) were not sure.

Table 4.36: t-test result for buying condom being embarrassing by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	11.29	25.3
Females	5	29.0	15.18	33.9
Mean difference	-9.8			
95% CI	-53.4	to 33.8		
SE	18.92			
t statistic	-0.52			
DF	8.0			
2-tailed p	0.6184			

There was no statistical significant difference between the male and female group (0.6184>0.05 table 4.36).

4.3.3.5.4 Using condom to prevent the spread of HIV/AIDS is more trouble than it's Worth

Figure 4.33 shows gender response to the stated item above.

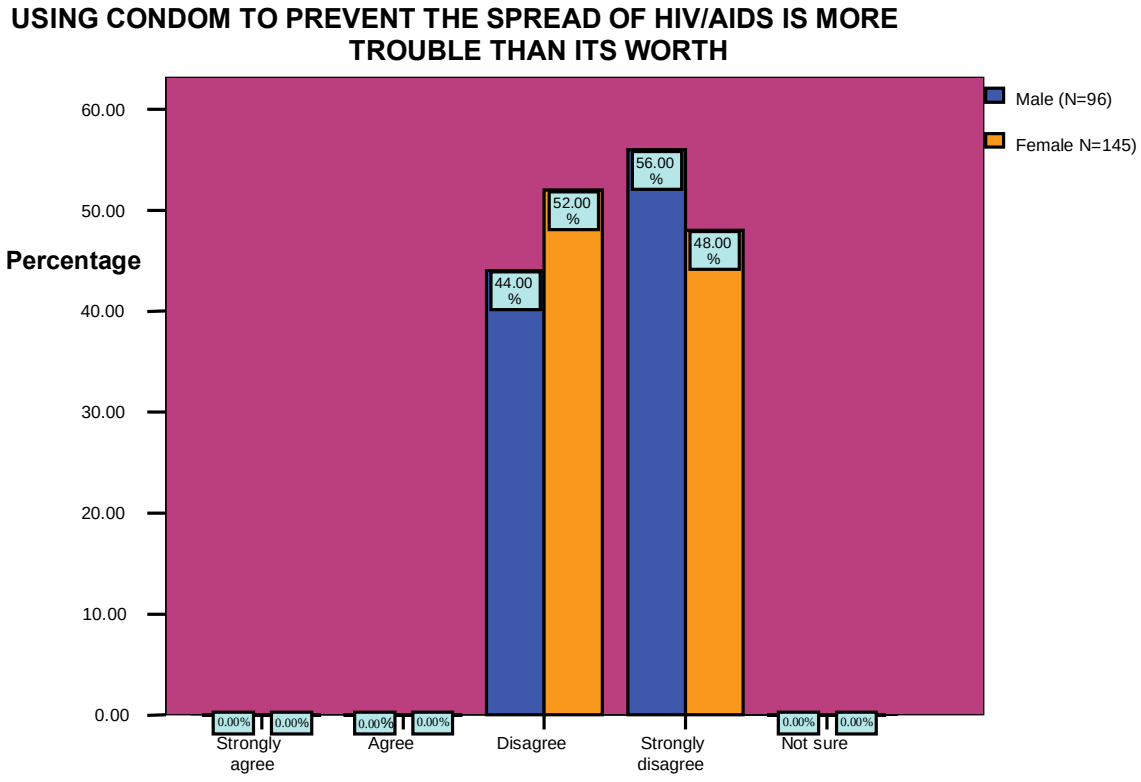

Figure 4.33

Condom being more trouble than its worth by gender

Fourty two (44%) males disagreed to 75 (52%) females that disagreed while 54 (56%) males strongly disagreed to 70 (48%) females that strongly disagreed. None of the respondent strongly agreed, agreed or were not sure in both groups.

Table 4.37: t-test result for condom being more trouble more than its worth by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	11.91	26.6
Females	5	29.0	17.78	39.7
Mean difference	-9.8			
95% CI	-59.1	to 39.5		
SE	21.40			
t statistic	-0.46			
DF	8.0			
2-tailed p	0.6591			

There was no statistical significant difference between the male and female group (0.6591>0.05 table 4.37).

4.3.3.5.5 Condoms are not easy to use

Figure 4.34 shows the responses of males and females to the stated item above.

None of the respondents strongly agreed or agreed. Sixty two males (65%) disagreed while 34 (35%) strongly disagreed. Females that disagreed were 15 (10%) and 127 (88%) strongly disagreed while 3 (2%) were not sure.to the stated item above.

Table 4.38: t-test result for condoms not easy to use by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	12.56	28.1
Females	5	29.0	24.66	55.1
Mean difference	-9.8			
95% CI	-73.6	to 54.0		
SE	27.67			
t statistic	-0.35			
DF	8.0			
2-tailed p	0.7324			

There was no statistical significant difference between the male and female group (0.7324>0.05 table 4.38).

4.3.3.5.6 Discussing using condom with someone is not embarrassing

Figure 4.34 presents by gender the responses of young people to the item stated above.

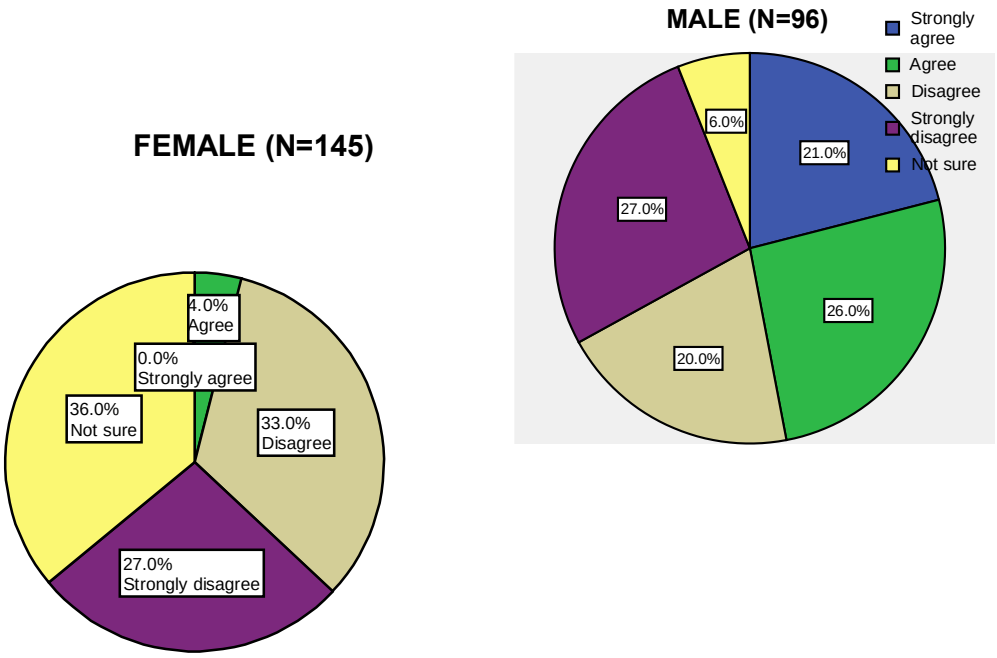

Figure 4.34

Discussing using condom not embarrassing by gender

Males had 20 (21%) that strongly agreed, 25 (26%) that agreed, 19 (20%) that disagreed, 26 (27%) that strongly disagreed and 6 (6%) that were not sure that discussing using condom with someone is not embarrassing.

Females had no respondent that strongly agreed, 6 (4%) agreed, 48 (33%) disagreed, 39 (27%) strongly disagreed and 52 (36%) were not sure to the stated item above.

Table 4.39: t-test result for discussing using condom not embarrassing by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	3.57	8.0
Females	5	29.0	10.86	24.3
Mean difference	-9.8			
95% CI	-36.2	to 16.6		
SE	11.43			
t statistic	-0.86			
DF	8.0			
2-tailed p	0.4163			

There was no statistical significant difference between the male and female group (0.4163>0.05 table 4.39).

4.3.3.5.7 Condom reduces the quality of sex so much that it is better not to use it at all

Figure 4.35 shows responses by gender to the stated item above.

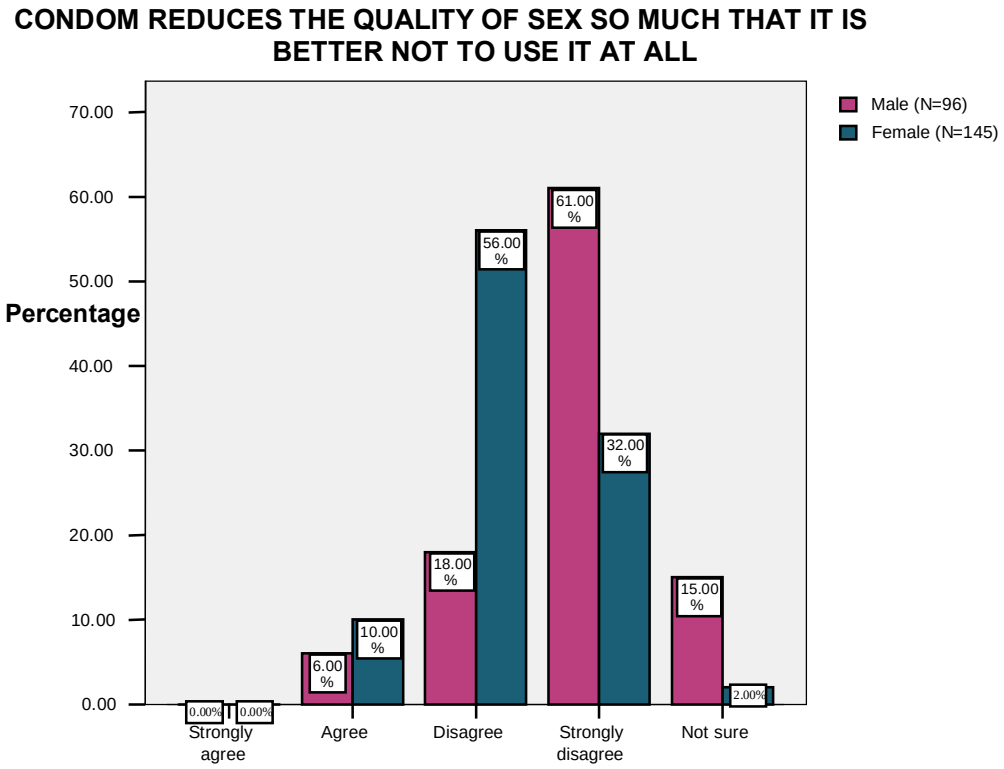

Figure 4.35

Condom reducing quality of sex by gender

No male or female respondent strongly agreed that condom reduces the quality of sex so much that it is better not to use at all. Six (6%) males agreed, 17 (18%) disagreed, 59 (61%) strongly disagreed and 14 (15%) were not sure while 15 (10%) females agreed, 81 (56%) disagreed, 47 (32%) strongly disagreed and 2 (2%) were not sure to the stated item above.

Table 4.40: t-test result for condom reducing quality of sex by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	10.39	23.2
Females	5	29.0	15.48	34.6
Mean difference	-9.8			
95% CI	-52.8	to 33.2		
SE	18.65			
t statistic	-0.53			
DF	8.0			
2-tailed p	0.6134			

There was no statistical significant difference between the male and female group (0.6134>0.05 table 4.40).

4.3.3.5.8 Condoms should be used in casual encounters and not in steady relationships

Figure 4.36 shows responses of males and females to the stated item above. Thirty three (34%) males strongly agreed, 62 (65%) agreed, 1 (1%) disagreed while none of the respondent strongly disagreed or were not sure towards condoms being used in casual encounters and not in steady relationship.

Eight (6%) females strongly agreed, 7 (5%) agreed, 32 (22%) disagreed, 60 (41%) strongly disagreed while 38 (26%) were not sure to the stated item above.

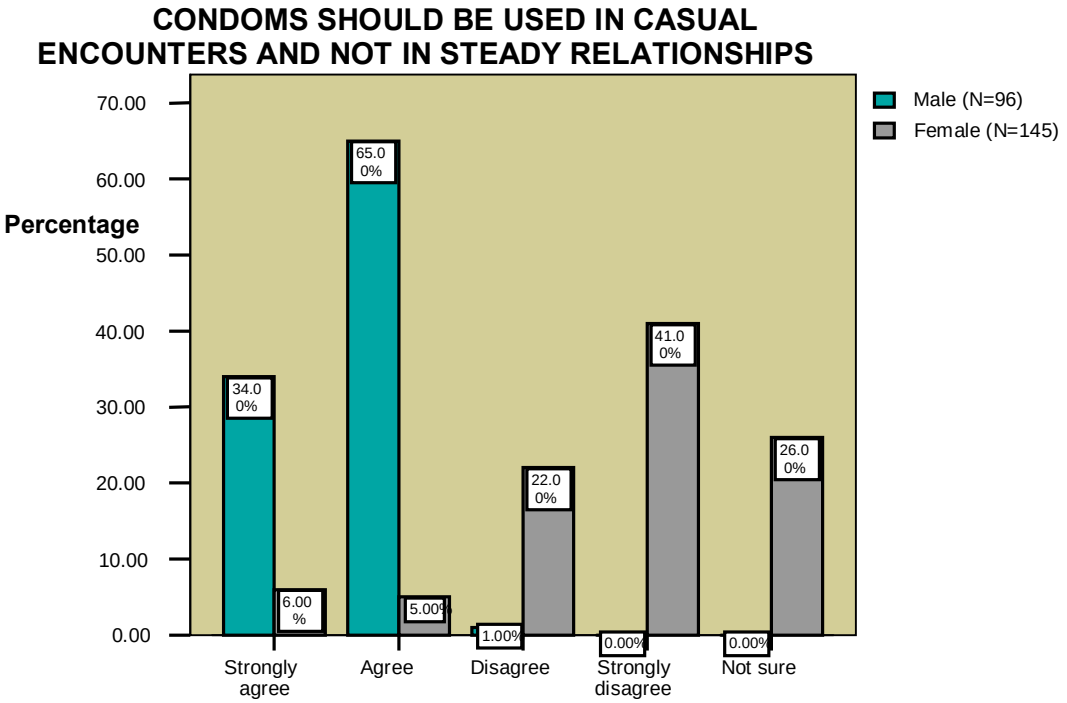

Figure 4.36

Condoms being used in casual encounters and not in steady relationship by gender

Table 4.41: t-test result for condoms being used in casual encounters and not in steady relationships by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	12.43	27.8
Females	5	29.0	9.94	22.2
Mean difference	-9.8			
95% CI	-46.5	to 26.9		
SE	15.92			
t statistic	-0.62			
DF	8.0			
2-tailed p	0.5552			

There was no statistical significant difference between the male and female group (0.5552>0.05 table 4.41).

4.3.3.5.9 Use of condom with a steady partner indicates lack of trust.

Figure 4.37 presents the responses by gender to the item stated above.

Fifty (52%) males strongly agreed, 46 (48%) agreed while none disagreed or strongly disagreed or were not sure that the use of condom with a steady partner indicates lack of trust. Twelve (8%) females strongly agreed, 96 (66%) agreed, 19 (13%) disagreed, 7 (5%) strongly disagreed while 11 (8%) were not sure to the stated item above.

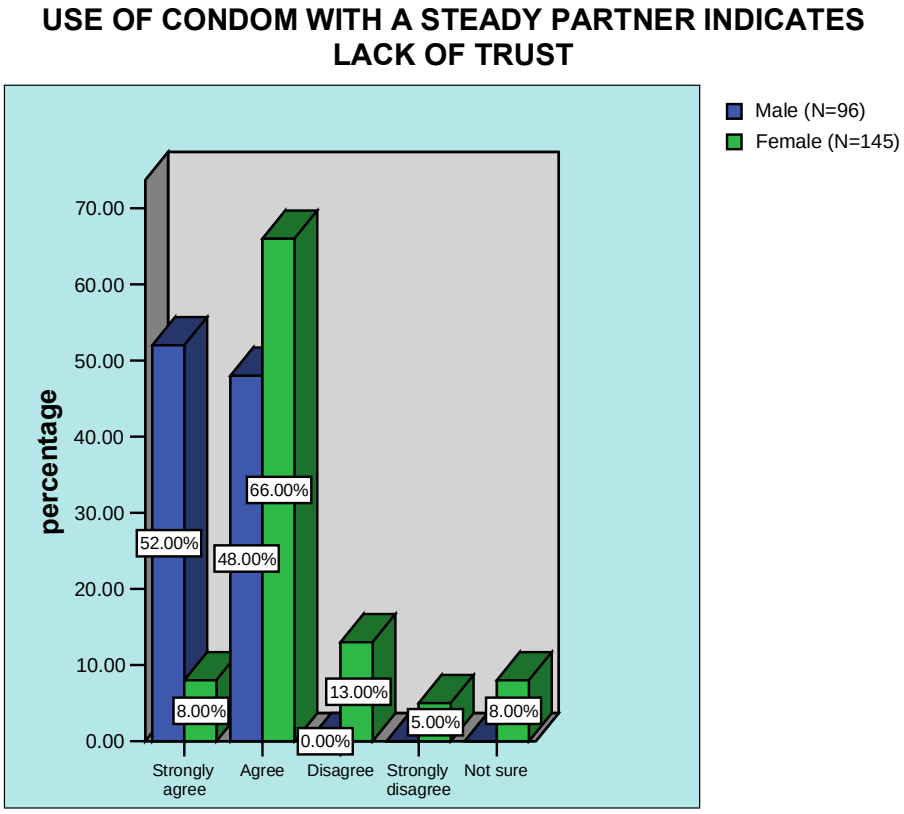

Figure 4.37

Lack of trust with steady partner by gender

Table 4.42: t-test result for lack of trust with steady partner by gender

n	10			
Groups	n	Mean	SE	SD
Males	5	19.2	11.77	26.3
Females	5	29.0	16.86	37.7
Mean difference	-9.8			
95% CI SE	-57.2 20.57	to 37.6		
t statistic	-0.48			
DF	8.0			
2-tailed p	0.6464			

There was no statistical significant difference between the male and female group (0.6464>0.05 table 4.42).

4.3.3.6 Attitude towards condom by age group

Another objective of the study is to establish if the attitudes of young people aged 15ï 25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana differed for age groups 15-19 and 20-25 years. The report on attitudes of young people was done according to age group in order to show comparison of attitudes between the two age groups.

4.3.3.6.1 Using condom does not help to prevent HIV/AIDS

Figure 4.38 shows the responses of young people towards the stated item by age. In the age group 15-19, no respondent strongly agreed or were not sure, 2 (1%) agreed, 68 (46%) disagreed, 80 (53%) strongly disagreed that using condom does not help prevent HIV/AIDS.

In age group 20-25, 4 (4%) strongly agreed, 61 (67%) disagreed, 26 (29%) strongly disagreed while no respondent strongly agreed or were not sure to the stated item above.

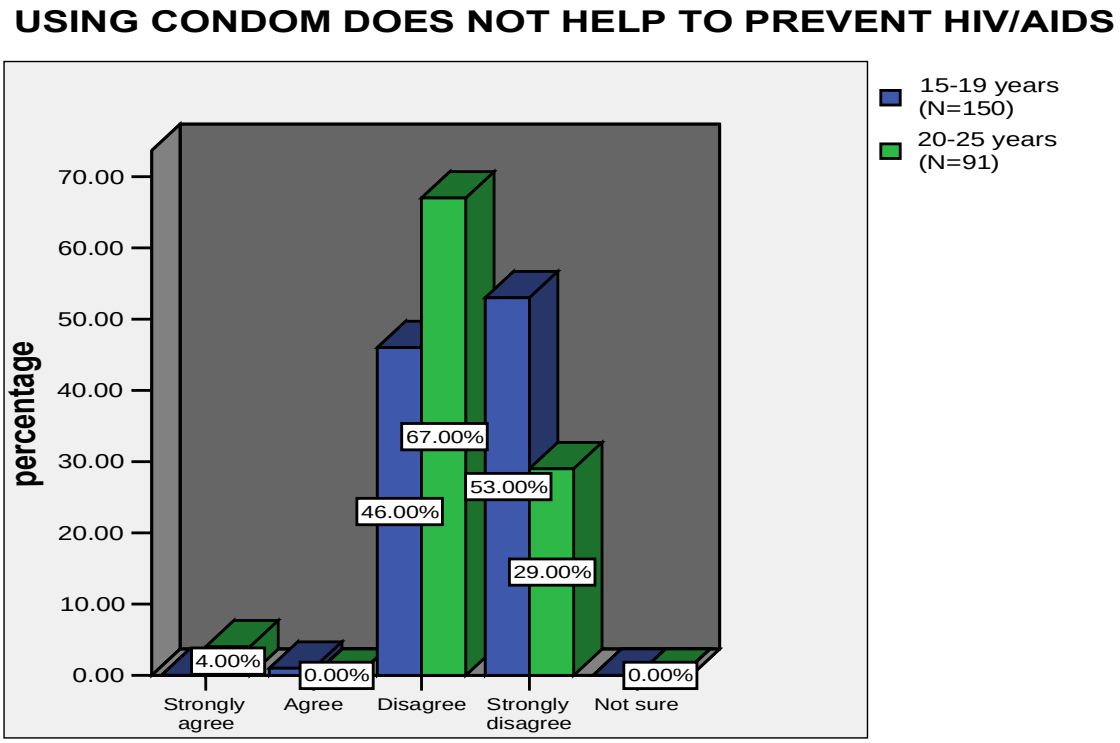

Figure 4.38

Condom helping to prevent HIV/AIDS by age group

Table 4.43: t-test result for condom helping to prevent HIV/AIDS by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	18.07	40.4
20-25 Yrs	5	18.2	11.74	26.3
Mean difference	11.8			
95% CI	-37.9	to 61.5		
SE	21.55			
t statistic	0.55			
DF	8.0			
2-tailed p	0.5989			

There was no statistical significant difference between the two age groups (0.5989>0.05 table 4.43).

4.3.3.6.2 If I love my partner, I will prove my love for him/her by having sex with him/her without using a condom

There was no respondent among the age group 15-19 years and 20-25 years who strongly agreed that if they love their partners they will prove their love by having sex with them without a condom. Fifteen (10%) of age group 15-19 agreed, 100 (67%) disagreed, 20 (13%) strongly disagreed, 15 (10%) were not sure and no respondent strongly agreed with the statement. Of the 20-25 years age group, 10 (11%) agreed, 28 (31%) disagreed, 23 (25%) strongly disagreed and 30 (33%) were not sure to the stated item below (see figure 4.39 below).

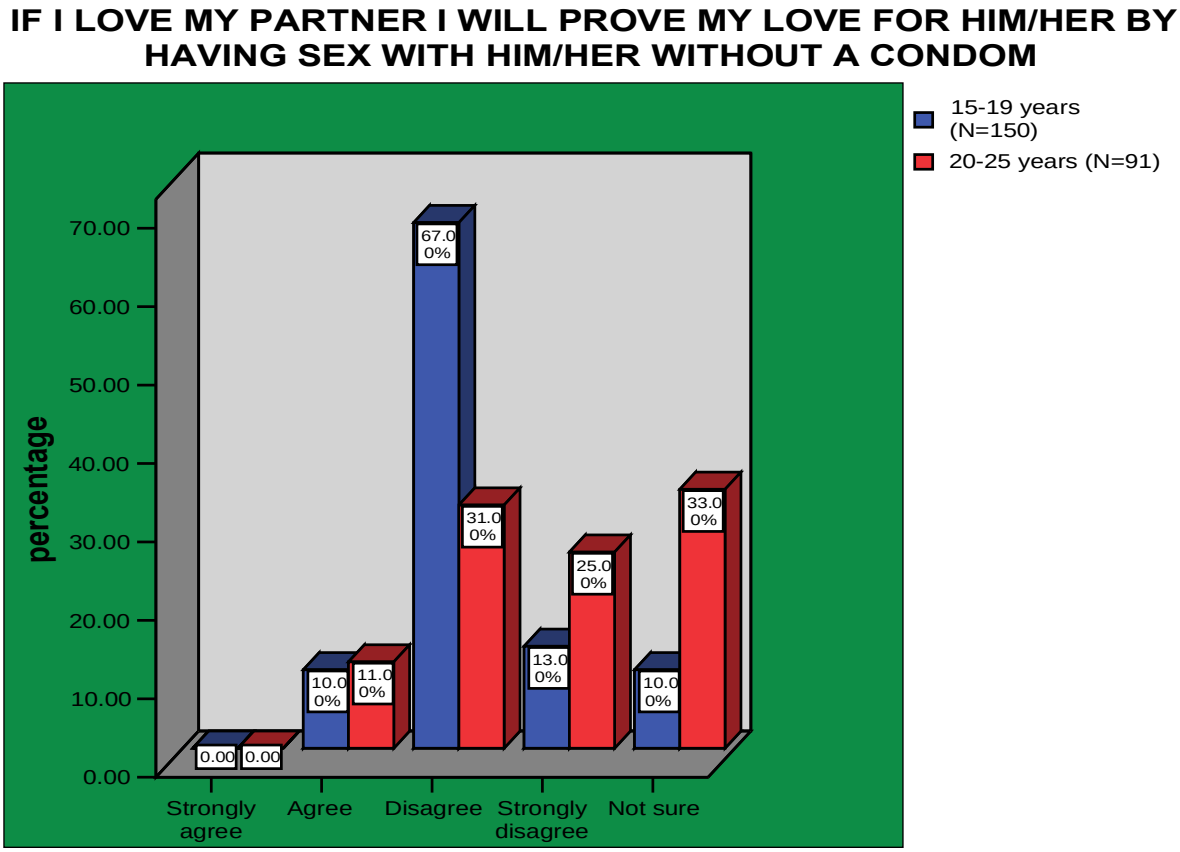

Figure 4.39

Proof of love by having sex without a condom by age group

Table 4.44: t-test result for proof of love by having sex without a condom by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	17.82	39.8
20-25 Yrs	5	18.2	5.73	12.8
Mean difference	11.8			
95% CI	-31.4	to 55.0		
SE	18.72			
t statistic	0.63			
DF	8.0			
2-tailed p	0.5460			

There was no statistical significant difference between the two age groups (0.5460>0.05 table 4.44).

4.3.3.6.3 Buying condom is embarrassing

The number of respondents in age group 15-19 that strongly agreed that buying condom is embarrassing was 72 (48%), 65 (43%) agreed, 10 (7%) disagreed no respondent strongly disagreed while 3 (2%) were not sure.

Age group 20-25 had 10 (11%) that strongly agreed, 7 (8%) that agreed, 5 (6%) that disagreed, 69 (75%) that strongly disagreed and none of the respondent were not sure (see figure 4.40).

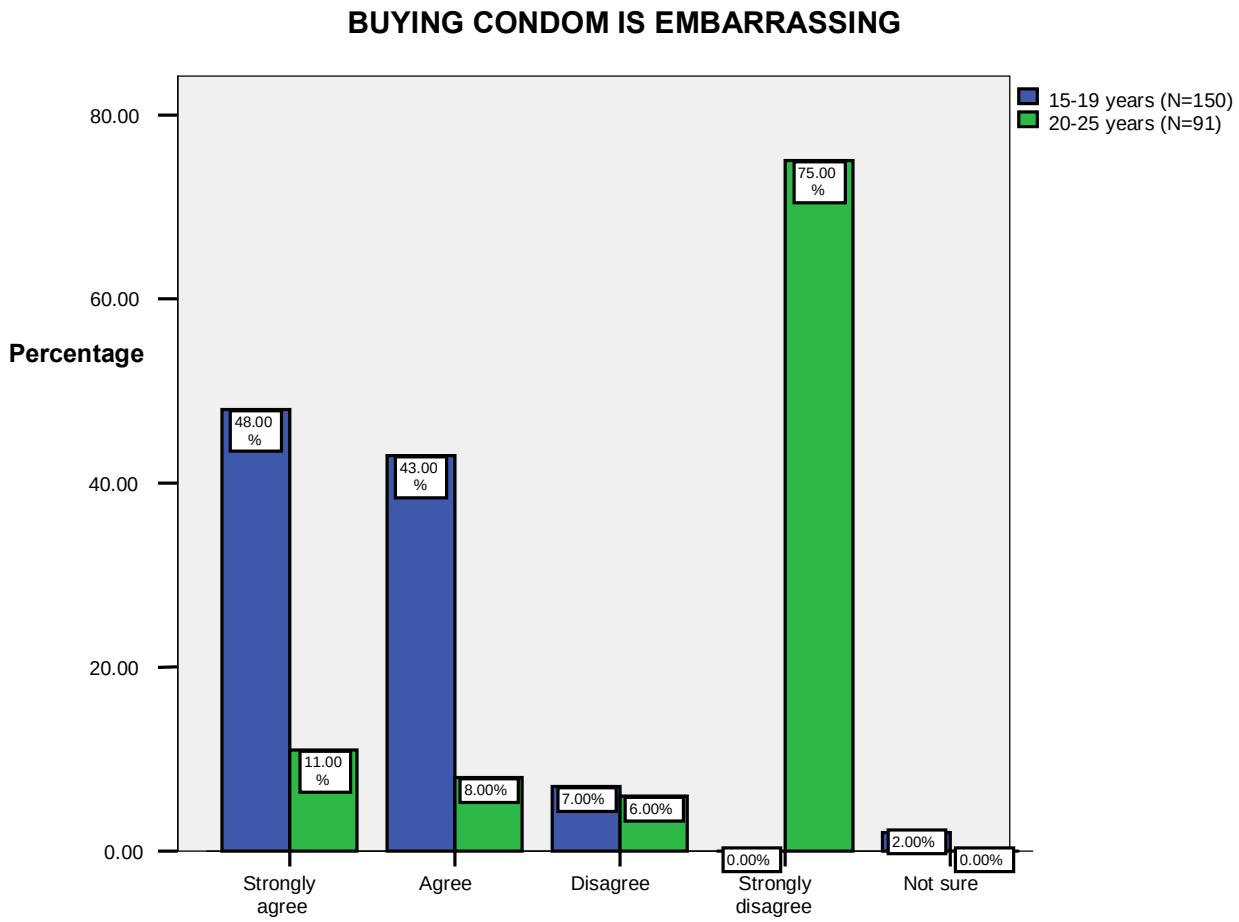

Figure 4.40

Buying condom being embarrassing by age group

Table 4.45: t-test result for buying condom being embarrassing by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	15.84	35.4
20-25 Yrs	5	18.2	12.80	28.6
Mean difference	11.8			
95% CI	-35.2	to 58.8		
SE	20.37			
t statistic	0.58			
DF	8.0			
2-tailed p	0.5783			

There was no statistical significant difference between the two age groups (0.5783>0.05 table 4.45).

4.3.3.6.4 Using condom to prevent the spread of HIV/AIDS is more trouble than it's worth

Figure 4.41 shows the responses to the stated item above by age. All the respondents both 15-19 years and 20-25 years disagreed that using condom to prevent the spread of HIV/AIDS is more trouble than its worth. Of the age group 15-19, 86 (57%) disagreed, 64 (43%) strongly disagreed while age group 20-25, 31 (34%) disagreed and 60 (66%) strongly disagreed. None of the respondents in both age groups strongly agreed or agreed or were not sure to the stated item above.

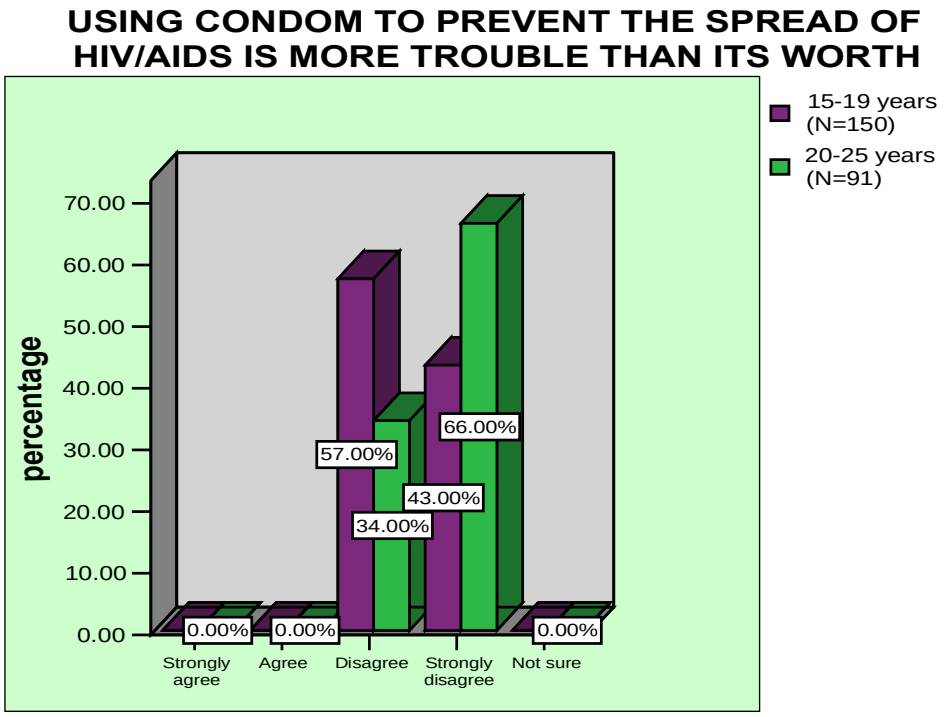

Figure 4.41

Condom being more trouble than its worth by age group

Table 4.46: t-test result for condom being more trouble more than its worth by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	18.70	41.8
20-25 Yrs	5	18.2	12.05	26.9
Mean difference	11.8			
95% CI	-39.5	to 63.1		
SE	22.24			
t statistic	0.53			
DF	8.0			
2-tailed p	0.6102			

There was no significant difference between the groups (0.6102>0.05 table 4.46).

4.3.3.6.5 Condoms are not easy to use

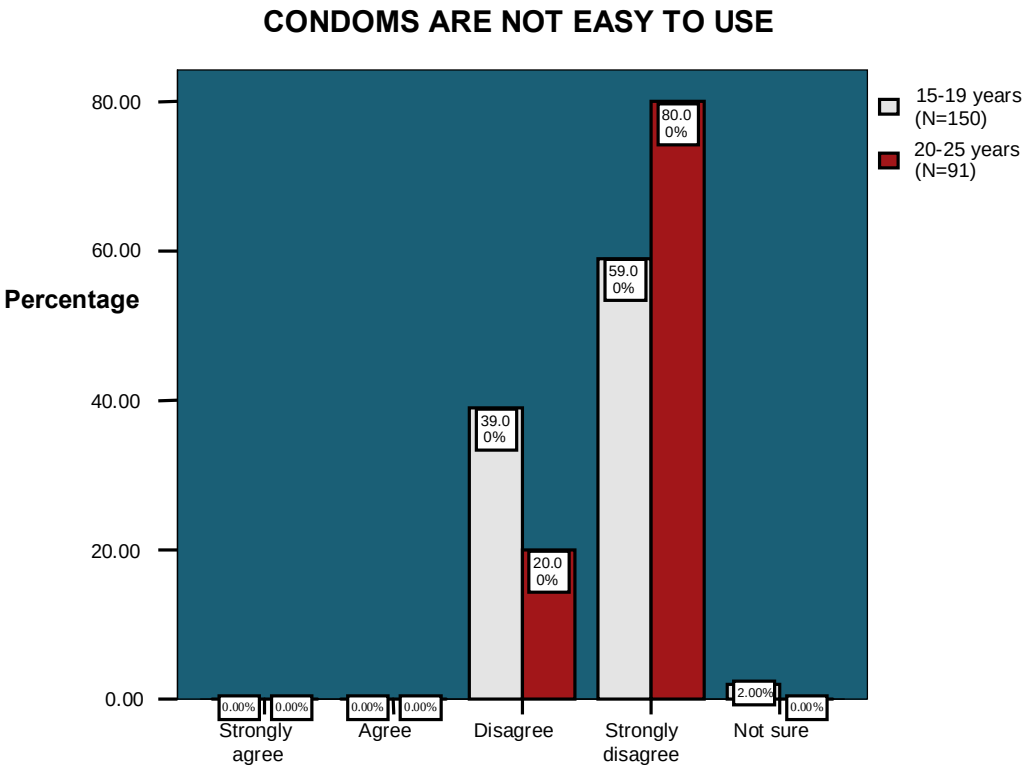

Figure 4.42

Condoms not easy to use by age group

Most of the respondents agreed that condoms are easy to use except 3 (2%) in the age group 15-19 who were not sure if condoms are easy to use or not. Fifty nine (39%) of the age group 15-19 disagreed, 88 (59%) strongly disagreed while in age group 20-25, 31 (34%) disagreed and 73 (80%) strongly disagreed (figure 4.42).

Table 4.47: t-test result for condoms not easy to use by age group

n	10			
Groups	N	Mean	SE	SD
15-19 Yrs	5	30.0	18.35	41.0
20-25 Yrs	5	18.2	14.14	31.6
Mean difference	11.8			
95% CI	-41.6	to 65.2		
SE	23.16			
t statistic	0.51			
DF	8.0			
2-tailed p	0.6242			

There was no statistical significant difference between the two age groups (0.6242>0.05 table 4.47).

4.3.3.6.6 Discussing using condom with someone is not embarrassing

Twenty (22%) strongly agreed and 31 (34%) agreed in 20-25 years age group that discussing using condom with someone is not embarrassing while none of the respondent in 15-19 years age group agreed or disagreed to that. Fifty five (37%) in the age group 15-19 disagreed, 60 (40%) strongly disagreed and 35 (23%) were not sure. Of the age group 20-25, 12 (13%) disagreed, 5 (6%) strongly disagreed and 23 (25%) were not sure (see figure 4.43 below).

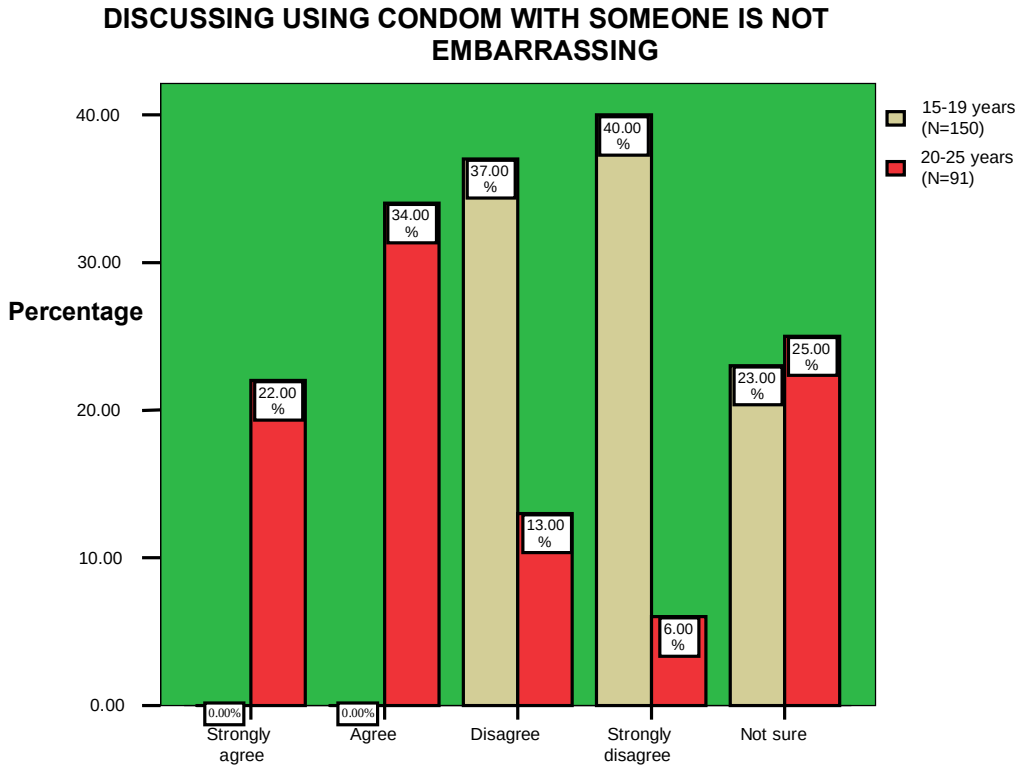

Figure 4.43

Discussing using condom not embarrassing by age group

Table 4.48: t-test result for discussing using condom not embarrassing by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	12.94	28.9
20-25 Yrs	5	18.2	4.49	10.0
Mean difference	11.8			
95% CI	-19.8	to 43.4		
SE	13.70			
t statistic	0.86			
DF	8.0			
2-tailed p	0.4141			

There was no statistical significant difference between the two age groups (0.4141>0.05 table 4.48).

4.3.3.6.7 Condom reduces the quality of sex so much that it is better not to use it at all

Few of the respondents 9 (6%) in age group 15-19, and 12 (13%) in age group 20-25 agreed that condom reduces the quality of sex so much that it is better not to use at all, Most of the respondents 78 (52%) disagreed and 48 (32%) strongly disagreed in 15-19 years age group. Twenty (22%) disagreed and 58 (64%) strongly disagreed in 20-25 years age group. Fifteen (10%) were not sure in age group 15-19 while 52 (36%) were not sure in age group 20-25 to the stated item above (see figure 4.44).

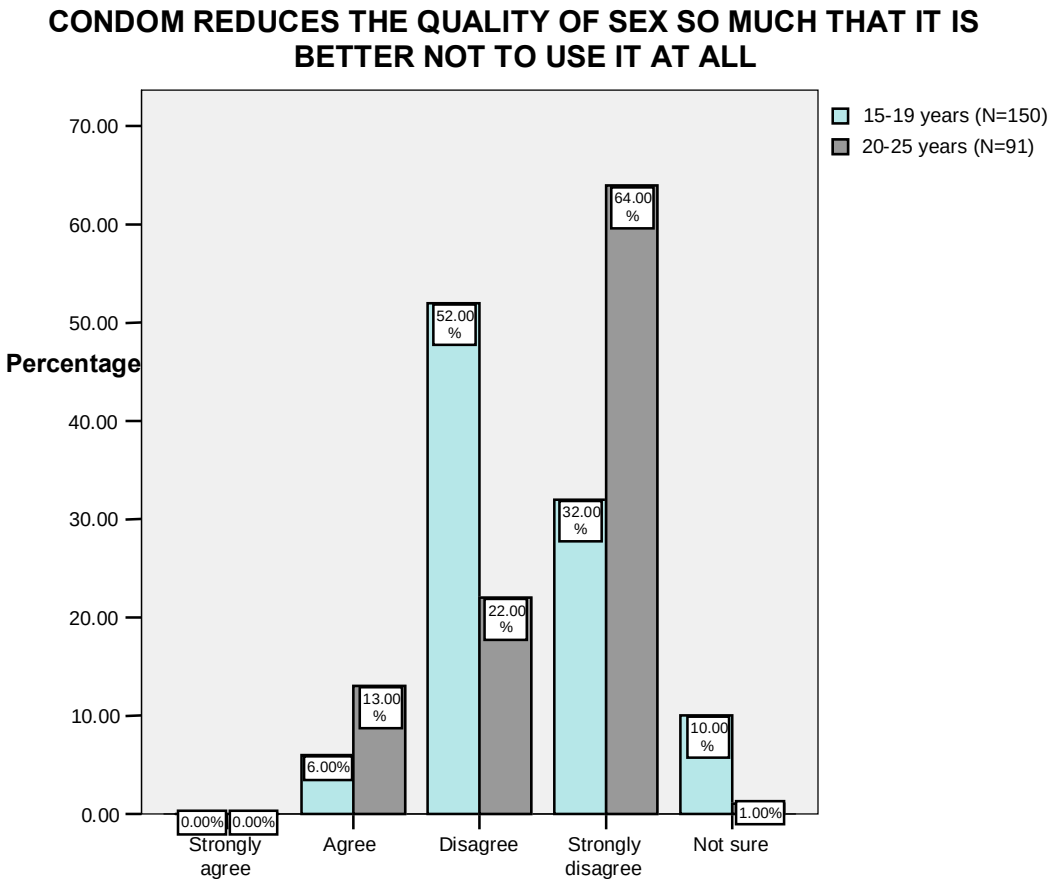

Figure 4.44

Condom reducing quality of sex by age group

Table 4.49: t-test result for condom reducing quality of sex by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	14.48	32.4
20-25 Yrs	5	18.2	10.61	23.7
Mean difference	11.8			
95% CI	-29.6	to 53.2		
SE	17.95			
t statistic	0.66			
DF	8.0			
2-tailed p	0.5295			

There was no statistical significant difference between the two age groups (0.5295>0.05 table 4.49).

4.3.3.6.8 Condoms should be used in casual encounters and not in steady relationships

Twenty five (17%) in the age group 15-19 strongly agreed, 14 (9%) agreed, 25 (17%) disagreed, 60 (40%) strongly disagreed while 26 (17%) were not sure that condoms should be used in casual encounters and not in steady relationships.

Age group 20-25 had 16 (18%) that strongly agreed, 55 (60%) that agreed, 8 (9%) that disagreed, 12 (13%) that were not sure and no respondent that strongly disagreed (see figure 4.45 below).

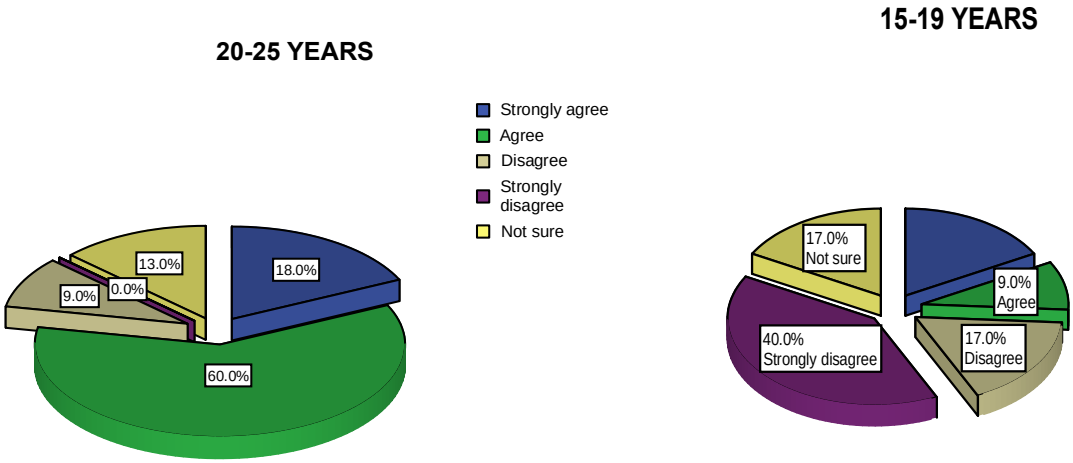

Figure 4.45

Condoms being used in casual encounters and not in steady relationships by age group

Table 4.50: t-test result for condoms being used in casual encounters and not in steady relationships by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	7.82	17.5
20-25 Yrs	5	18.2	9.57	21.4
Mean difference	11.8			
95% CI	-16.7	to 40.3		
SE	12.36			
t statistic	0.95			
DF	8.0			
2-tailed p	0.3676			

There was no statistical significant difference between the two age groups (0.3676>0.05 table 4.50).

4.3.3.6.9 Use of condom with a steady partner indicates lack of trust.

In age group 15-19, 20 (13%) strongly agreed, 115 (77%) agreed, 9 (6%) disagreed, 6 (4%) were not sure and none of the respondent strongly disagreed.

Of the age group 20-25, 42 (46%) strongly agreed, 27 (30%) agreed, 10 (11%) disagreed, 7 (8%) strongly disagreed and 5 (5%) were not sure that use of condom with a steady partner indicates lack of trust (see figure 4.46 below).

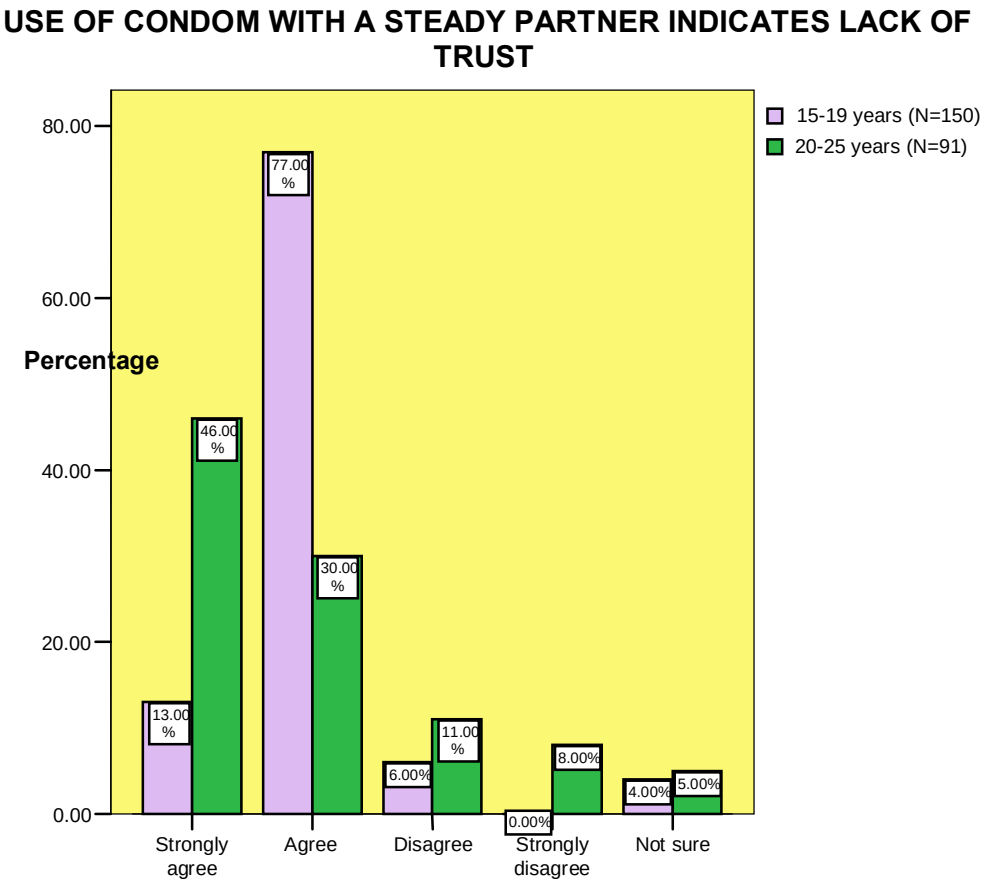

Figure 4.46

Lack of trust with steady partner by age group

Table 4.51: t-test result for lack of trust with steady partner by age group

n	10			
Groups	n	Mean	SE	SD
15-19 Yrs	5	30.0	21.50	48.1
20-25 Yrs	5	18.2	7.11	15.9
Mean difference	11.8			
95% CI	-40.4	to 64.0		
SE	22.64			
t statistic	0.52			
DF	8.0			
2-tailed p	0.6164			

There was no statistical significant difference between the two age groups (0.6164>0.05 table 4.51).

4.4 CONCLUSION

This chapter presented the results of the analysis of the data by quantitative method using tables, pie charts and bar charts. Inferential statistics were used to determine the significant difference between the groups used. The findings showed how young people responded to the scales used in the questionnaire to determine their attitude to ñABCò strategy for prevention. The next chapter will discuss the findings and limitations of the research and make recommendations based on the findings.

CHAPTER 5

DISCUSSION OF FINDINGS

5.1 INTRODUCTION

In this chapter, a summary of the findings of the study is discussed. This is followed by the conclusions drawn, limitations of the study as well as the recommendations made.

5.2 OVERVIEW OF THE STUDY

The purpose of the study was to determine the attitudes of young people aged 15-25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana.

The objectives of the study were to:

- Describe the attitude of young people aged 15-25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana.
- Establish if the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana differ for males and females.
- Establish if the attitudes of young people aged 15-25 years towards ñABCò strategy in the prevention of HIV/AIDS in Francistown, Botswana differ for age groups 15-19 and 20-25 years.
- Make recommendations regarding the strategies that can be used to foster positive attitudes in young people aged 15-25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana.

The research questions that guided the study were:

- What is the attitude of young people aged 15-25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown, Botswana?
- Do attitudes of young (15-25 years) people towards the ñABCòstrategy for the prevention of HIV/AIDS in Francistown, Botswana differ for males and females?
- Do attitudes of young (15-25 years) males and females towards the ñABCò strategy for the prevention of HIV/AIDS in Francistown, Botswana differ for age groups 15-19 years and 20-25 years?

5.3 SUMMARY AND INTERPRETATION OF RESULTS

5.3.1. Social demographic profile of respondents

For the purpose of this study the term young people was used to represent the people between the ages 15ï 25 years. Two hundred and forty one (241) young people participated in the study. This is the group mostly found in junior and secondary schools, institutions of higher learning and some at places of work.

Both male and female young people were represented in the sample that participated in the study. The majority of 145 (60%) respondents aged 15-25 years were females as compared to 96 (40%) males

The number of respondents (male and female) aged 15-19 years 150 (62%) was higher than 91 (38%) in the age range of 20-25 years. All the young people who participated in the study resided in Francistown.

There were variations in terms of the level of education because all the respondents had a level of education at one time in their life or were still in the system of education. The implication was that the respondents were literate and could read and understand written and verbal health information on ñABCò strategy for preventing HIV/AIDS.
As the majority of respondents were still at secondary schools and institutions of higher learning, a small number of respondents were employed.

5.3.2 Attitudes of young people

5.3.2.1 Abstinence

The young people had positive attitude towards sexual activites not being compulsory to be engaged into, them feeling comfortable talking about abstinence, abstinence needing discipline and will power, sexual intercourse not being the only way two people could know each other and them thinking carefully before engaging into sexual relations.

The young people had negative attitude when they were asked if they could postpone their sexual relation until they were responsible to take care of their action.

The young people had ambivalent attitude towards them proving their love by having sex with their partners.

There were no statistical significant differences between the age groups as well as the males and the females.

5.3.2.2 Being faithful

The young people had positive attitude and agreed that faithfulness is very important in a relationship, it is possible to contract HIV/AIDS from a regular partner, it is important that one should talk to his/her partner about HIV/AIDS and long time partner not being boring.

In contrary, the young people had negative attitude towards sex meant for only two trusted people.

The young people had positive and ambivalent attitude at the same time towards communication with partner about their positive status if they had HIV/AIDS and they were neutral meaning they had positive and negative attitude towards having sex with many people does not make sex more enjoyable.

5.3.2.3 Condom

The young people had positive attitude to some extend when it applied to the use of condom like they agreed condom helps prevent HIV/AIDS, them not proving their love by having sex without a condom with their partners, condom not being trouble than its worth, condom being easy to use and condom not reducing the quality of sex that it is better not to use it at all.

In contrary, the young people had negative attitude when they were asked if condom should be used in casual encounters and not steady relationship, they did not believe condom should be used in steady relationship. They also had negative attitude towards them discussing the use of condom with partner and embarrassment of buying condom.

There were no statistical significant differences between the age groups as well as the males and the females.

5.4 FINDINGS AS RELATED TO THE HEALTH BELIEF MODEL

5.4.1 Attitude of young people towards the 'ABC' strategy of HIV/AIDS prevention

5.4.1.1 Perceived susceptibility

Most of the respondents (62%) agreed that it is possible to contract HIV/AIDS from a regular partner. From the finding, the young people perceived themselves susceptible to contracting HIV/AIDS from a regular partner. This result is consistent with the findings on sexual abstinence behaviour among youths in a generalized HIV epidemic country that one can get infected even from a regular partner (Koffi and Kawahara 2008:1486).

As many as 68% of the respondents felt that they will not have sex with their partners without a condom. This is an indication that the respondents do perceive chances of contracting HIV/AIDS if they prove their love by having sex without a condom. These finding is consistent with those of a study by Wodi (2005:93) which found that the majority of adolescents in Nigeria stated that they would always use condom when they have sex with their partners. Another study by Marandu and Chamme (2004:500) also revealed that the young people agreed that it is not difficult for them to suggest condom to a person when in love, but when the young people in this study were asked if they will prove their love by having sex with their partners, a noteworthy observation showed that 51% of respondents were not sure if they will prove their love by having sex with their partners or not. Only 36% of respondents felt that they will not prove their love for their partners by having sex.

The majority of respondents did not perceive themselves as being susceptible of contracting HIV/AIDS when they were asked if only the two people who trust each other completely should have sexual relations, a large percentage of respondents (96%) disagreed to it. This is in line with a report that the female youths in Zambia had multiple sexual partners to escape poverty, whilst male youths engaged in multiple

sexual relationships to prove their masculinity. The female youths felt unable to change their own behaviours to practice fidelity due to the economic ties around multiple sexual partnerships (Masimba 2008).

5.4.1.2 Perceived severity

All the young people perceived the severity of HIV/AIDS by indicating that condom worths preventing the spread of HIV/AIDS but in contrary to the practice of condom, fifty two *(*52%) of the young people believed that condoms should be used in casual encounters and not in steady relationships and 83% agreed that the use of a condom with a steady partner indicates lack of trust. These results are also consistent with a study by Manji, Pena and Durbrow (2007:990) where majority of young people believed condoms should be used with occasional sex partners and not in steady relationship. The belief was when a relationship moves from casual to serious, it is no longer necessary to use condoms. Another study by Odu et al (2008:93) revealed that the majority of the sexually active respondents stated they occasionally or never used condoms with persons they believed they could trust. These findings suggest that young people do not perceive the seriousness of HIV/AIDS and they believed condoms should not used in steady relationships.

5.4.1.3 Perceived benefits

A large percentage (92%) of respondents agreed that abstinence needs discipline and will power. The young people knew that discipline and willpower were components to benefit when abstaining. All the respondents knew the benefit of keeping a relationship faithful by agreeing that faithfulness to one sexual partner is important in a relationship.

As many as 97% of respondents knew that using a condom helps prevent the spread of HIV/AIDS. From the findings it indicated that all young people perceived the benefit of using condom which prevents HIV/AIDS. This result is consistent with that of Maharaj (2006:29) where, the majority of young people agreed that condom protects against HIV infection. Thirty nine(39%) of the respondents believed that there is no benefit in having sex with many people while 36% thought that having sex with many people makes sex enjoyable.

The number that perceived the benefit of being faithful to one partner and not thinking that sex with many people makes sex enjoyable was not much from the number that did not perceive the benefit.

5.4.1.4 Perceived barriers

The young people did not perceive having same partner for a long time as a barrier to being faithful. The majority of the young people (53%) believed that it is not boring to have the same sexual partner for a long time. Almost all the young people (99%) believed that condoms are easy to use. It indicated that condom not being easy to use is not a barrier.

Majority (85%) of the young people believed that condom does not reduce the quality of sex so much that it is better not to use it at all. Five percent of these young people were ambivalent. This is consistent with a study where majority of the young people agreed that condoms do not reduce sexual sensation (Marandu and Chamme 2004:500). This showed that young people perceived that condom reducing quality of sex is not a barrier for them to the use of condom in preventing HIV/AIDS.

The findings of the study also demonstrated that 55% young people agreed that buying is embarrassing. Young people perceived buying condom a barrier. This is consistent with a large proportion of young people in other studies that indicated that buying condoms is embarrassing (Potsonen and Kontula 1999:211; Prata, Vahldnia and Fraser 2005:194).

5.4.1.5 Cues to action

From the finding it indicated that the desire for the young people to take action was high since they had a very high percentage (96%) that agreed that one should think carefully before engaging into sexual relation and a large percentage (94%) of young people also believed that sexual intercourse is not the only way one can get to know each other. Consistently a study by Lillie, Pulerwits and Curbow (2009:281) among the Kenyan in-school Youths revealed that majority would avoid sex while in a relation.

5.4.1.6 Self efficacy

The young people had confidence to talk about abstinence comfortably. The young people (79%) had positive attitude about feeling comfortable talking about abstinence.

Forty (40%) indicated that abstinence is not difficult to practice while 36% felt that it is difficult to practice and the remaining 24% was ambivalent. These findings are in line with those of many studies that, although young people agree that abstinence is the most effective and only certain way to avoid HIV transmission, they find it difficult to practice (Koffi and Kawahara 2008: 486; Morolong 2004:68; Sabone et al 2007:334). The percentage difference between the young people that had confidence that abstinence is not difficult to practice to those that had confidence that abstinence is difficult to practice was not much.

The young people did not feel they can postpone sex until they are able to take responsibility for their actions. The young peoplesôself efficacy to postpone sex thereby abstaining was low. From the result of this study, 59% of the majority had negative attitude towards the item ñ*It is posible to postpone sexual relations until a person is able to take responsibility for his or her action".*

Sixty five percent of the young people believed that it is not compulsory for them to engage in sexual activities. Among them, 53 (23%) did not believe while 31 (12%) were not sure. The findings demonstrated that these young people acknowledged the fact that sexual activities are not compulsory, that it was a matter of choice. The young people had confidence with a very high knowledge that sexual activities are not compulsory. The findings are consistent with the majority of Anguillan youths who indicated that they would like to wait until they are older before having sex (Kurtz, Douglas and Lugo 2005:41).

The efficacy to communicate to partner about HIV/AIDS was high because a large number of percentage (99%) of young people believed that it is important that one should talk with his/her partner about HIV/AIDS whereas the young peoplesôefficacy to

talk about HIV/AIDS to their partner if they find out they have HIV/AIDS was positive and ambivalent because there was not much difference in the number (47%) of young people that believed to those (42%) that were not sure if one contracts HIV/AIDS, one should talk about it with his or her partner.

Majority of the young people had low confidence discussing the use of condom with their partners when asked if discussing using condom with someone is embarrassing, 48% of these young people believed that it is embarrassing to discuss condom use with someone.

5.4.2 Attitude of young people towards the "ABC" strategy according to the gender of the participants (male and female young people)

5.4.2.1 Perceived susceptibility

The majority of the young people that were not sure whether or not they would prove their love by having sex with their partners showed that there were 62% males to 45% of females. There was no statistical significance difference between the males and the females ($t = -0.66$, $df = 8$ and $p = 0.5307$).

A large number of 88% females were susceptible to contracting HIV/AIDS to a smaller number of 43% males who also believed they were susceptible to contracting HIV/AIDS because they will not prove their love by having sex without using condom with their partners. The result also shows that more males (39%) were not sure to 6% females who were also not sure. The difference between the males and the females was not statistically significant ($t = -0.52$, $df = 8$ and $p = 0.6187$).

Majority of the males and the females perceived themselves susceptible to HIV/AIDS when the findings revealed that 61% females believed to 57 (59%) males that it is possible to contract HIV from a regular partner. There was no statistical significant difference between male and female group ($t = -1.28$, $df = 8$ and $p = 0.2372$).

Majority of the males (96%) and the females (93%) did not perceive themselves as being susceptible of contracting HIV/AIDS because a large percentage of respondent

did not believe that only the two people who trust each other completely should have sexual relations. Statistically the difference between the two groups was not significant (t = -0.38, df = 8 and *p* = 0.7114).

5.4.2.2 Perceived severity

All the male and female young people believed that condom worths preventing the spread of HIV/AIDS thereby perceiving the severity of HIV/AIDS. The finding gave a total of 100% result. The difference between the males and females was not statistically significant (t = -0.46, df = 8 and *p* = 0.6591). It is consistent with the majority young people in South Africa in a study by James, Reddy, Taylor and Jinabhai (2004:267) where majority males and females agreed that condom worths preventing HIV/AIDS.

A larger number (99%) of males did not perceive the seriousness of HIV/AIDS when compared to 63% females that did not perceive the seriousness of HIV/AIDS believing that condoms should be used in casual encounters and not in steady relationships. Female group had 26% that were not sure whether they perceive the seriousness or not while there was no respondent in the male group that was not sure.. The difference between the males and females was not statistically significant (t = -0.62, df = 8 and *p* = 0.5552).

All male respondents to 74% females did not perceive the seriousness of HIV/AIDS and believed that the use of condom with a steady partner indicates lack of trust. The difference between the males and females was not statistically significant (t = -0.48, df = 8 and *p* = 0.6464).

5.4.2.3 Perceived benefit

The findings from the gender displayed that, 92% males and 88% females knew that abstinence needs discipline and willpower. The difference between the males and females was not statistically significant (t = -0.50, df = 8 and *p* = 0.6295). All the males and females knew the benefit of faithfulness in a relationship. There was no statistically significant difference between the males and the females (t = -0.45, df = 8 and *p* = 0.6613). This is consistent with a study where majority of the young people

knew that being faithful is important in a relationship (James, Reddy, Taylor and Jinabhai 2004:267).

All 100% females to 94% males knew the benefit of condom in helping to prevent the spread of HIV/AIDS. Four (6%) males did not know the benefit of using condom to prevent the spread of HIV/AIDS. The difference between the males and females was not statistically significant (t = -0.47, df = 8 and *p* = 0.6528). This is consistent with a study by Maharaj (2006:29) where young people were asked if condom protects against HIV infection, 93.6% males and 94.6% females agreed that condom protects against HIV infection.

There was no statistical significant difference between the male and female group (t = -1.14, df = 8 and *p* = 0.2874) in the majority males 42% and females 37% that knew that there is no benefit in having sex with many people.

5.4.2.4 Perceived barrier

Most of the females (65%) and 52% males did not perceive having same partner for a long time as a barrier . The percentage number of males (43%) that perceived having the same partner for a long time boring a barrier were higher to 13% females who perceived it as barrier also. There was no statistical significant difference between the males and the females (t = -0.76, df = 8 and *p* = 0.4672).

All the males did not peceived condom not being easy to use as a barrier to 98% females who did not perceive it as a barrier. The remaining 2% of the females were ambivalent. The difference between the males and females was not statistical significant (t = -0.35, df = 8 and *p* = 0.7324). This is consistent with the findings in the study by Potsonen and Kontula (1999:214) which showed that boys regarded using condoms to be easier than girls.

Majority of the females (88%) and 79% males did not perceive any barrier in condom reducing the quality of sex so much that it is better not to use it at all. Fourteen (15%) males were ambivalent to 2 (2%) females. The difference between the male and female group was not statistically significant (t = -0.53, df = 8 and *p* = 0.6134).

A larger proportion of females (91%) perceived buying condom embarrasing than 76% males. There was no statistical significant difference between the males and the females (t = -0.52, df = 8 and *p* = 0.6187). This is in line with a study by Prata, Vahldnia and Fraser (2005:194) on gender and relationship differences in condom use among 15-24 year-olds in Angola which revealed that males were significantly less likely than females to feel embarrassed about buying condoms.

5.4.2.5 Cues to action

Ninety eight percent females and 93% males believed that one should think carefully before engaging into sexual relations. There was no statistical significant difference between the two groups (t = -0.44, df = 8 and *p* = 0.6703). The findings also showed that 94% males and 95% females thought that sexual intercourse is not the only way two people can get to know each other. Six percent males to 5% females thought otherwise. There was no statistical significant difference between the males and females (t = -0.41, df = 8 and *p* = 0.6933).

5.4.2.6 Self efficacy

Eighty percent majority males to 79% majority females had confidence talking about abstinence comfortably. There was no statistical significance difference between the males and the females (t = -0.66, df = 8 and *p* = 0.5261).
Fifty four percent females thought abstinence is not difficult to practice while 47% males thought that abstinence is difficult to practice. Thirty eight percent males were not sure to 18% females that were not sure. The difference between the males and females was not statistically significant (t = -1.21, df = 8 and *p* = 0.2600).

The percentages of males and females that believed it is not compulsory to be engaged in sexual activities were 64% of males and 63% of females. Thirty one percent females and 8% males thought otherwise. There was no statistical significant difference between the male and the female group (t = -0.87, df = 8 and *p* = 0.4085).

The young people were positive and ambivalent towards communicating with their partner about HIV/AIDS status if they have it. The males that had confidence to communicate with partner were (53%) to 44% females. The difference between the

males and females was not statistical significant (t = -0.60, df = 8 and *p* = 0.5654). In contrary to this finding , Tagoe and Aggor (2009:63) showed that the majority of respondents (62.8%) females indicated that they would have sexual relation without using condom with their partners because of the difficulty of discussing the status with their partner.

There is a very high efficacy to communicate with partner about HIV/AIDS between the males and the females (100% to 99%). The remaining 1% females was not sure . The difference between the two groups was not statistical significant (t = -0.46, df = 8 and *p* = 0.6566). Although almost all the respondents had positive attitude in this study, majority of the males and female in the study by James, Reddy, Taylor and Jinabhai (2004:266) said they would communicate with their partners about HIV/AIDS.

Majority of the males (66%) and females (58%) believed that it is not possible for them to postpone sexual relations until they are able to take responsibilities for their actions. There was no significant difference between the males and females (t = -1.11, df = 8 and *p* = 0.2995). The finding in this study is consistent among the Anguillan youths that said they would wait until they are older before having sex, (Kurtz, Douglas and Lugo 2005:41).

The percentage number of males (47%) that had low self efficacy discussing using condom with partner which they find embarrasing is the same to the number (47%) that find it not embarrasing while in female group, the percentage number that find it not embarrasing is 4% to 60% that find it embarrasing. There was no statistical significant difference between the males and females (t = -0.86, df = 8 and *p* = 0.4163).

5.4.3 Attitude of young people towards the "ABC" strategy according to the age groups 15-19 years and 20-25 years

5.4.3.1 Perceived susceptibility

From the finding, majority of the young people were not sure whether they were susceptible to HIV/AIDS by proving their love to their partner by having sex with them. The finding showed that 54% in the age group 15-19 years were not sure to 48% in age

group 20-25 years. There was no statistical significance difference between the two age groups (t = -0.73, df = 8 and *p* = 0.4865).

Most young people (67%) in age group 20-25 years and 56% in age group 15-19 perceived susceptibility of contracting HIV/AIDS from a regular partner. The difference between the two age groups was not statistically significant (t = -1.29, df = 8 and *p* = 0.2322).

Since majority of the young people aged 15-25 years perceived themselves susceptible to HIV/AIDS and believed that they will not prove their love by having sex without a condom with their partners. The two age groups showed that 80% in age group 15-19 perceived themselves susceptible to contracting HIV/AIDS to 56% of age group 20-25 who perceived themselves susceptible to HIV/AIDS. The difference between the two groups was not statistically significant (t = -0.63, df = 8 and *p* = 0.5460)

All the young people in age group 20-25 did not perceive themselves susceptible to contracting HIV/AIDS by disagreeing with the stated item *"Only the two people who trust each other completely should have sexual relations"*. Ninety one percent in age group 15-19 years did not perceive themselves susceptible to contracting HIV/AIDS. The difference between the two groups was not statistically significant (t = -0.46, df = 8 and *p* = 0.6545)

5.4.3.2 Perceived severity

All the young people in the two age groups perceived the severity of HIV/AIDS by indicating that condom worths preventing the spread of HIV/AIDS. The difference between the two age group was not statistically significant (t = -0.53, df = 8 and *p* = 0.6102).

More young people (57%) in age group 15-19 perceived the severity of HIV/AIDS by believing that condoms should also be used in steady relationships and 18% in age group 20 25 years whereas 76% in 20-25 years age group did not perceive the severity of HIV/AIDS to 26% in age group 15-19 years. The same number of percentage (17%)

in both groups were not sure if the perceived the severity of HIV/AIDS . The difference between the two groups was not statistically significant (t = -0.95, df = 8 and *p* = 0.3676).

A larger percentage (90%) of young people in age group 15-19 years did not perceive the severity of HIV/AIDS to 69 (76%) in age group 20-25 who did not perceive the severity of HIV/AIDS that the use of condom with a steady partner indicates lack of trust. The difference between the two groups was not statistically significant (t = -0.52, df = 8 and *p* = 0.6164).

5.4.3.3 Perceived benefit

All the young people in age group 20-25 knew the benefit of discipline and willpower in abstaining to 83% in 15-19 years age group that knew the benefits also. The difference between the two age groups was not statistically significant (t = -0.63, df = 8 and *p* = 0.5479).

All the young people in the two age groups knew the benefit of keeping a relationship faithful. There was no statistically significant difference between the two age group (t = -0.54, df = 8 and *p* = 0.6048).

Majority (43%) in age group 15-19 to 36% in age group 20-25 years knew that there is no benefit in having sex with many people. Many respondent (61%) in 20-25 years age group to 16 (11%) in age group 15-19 years believed that there is no benefit in having sex with many people. The difference between the two group was not statistically significant (t = -0.74, df = 8 and *p* = 0.4824).

Since almost all the young people in the two age group knew the benefit of condom in preventing HIV/AIDS the finding showed that only 1% in age group 15-19 to 3% in age group 20-25 did not know the benefit of condom as being important in the prevention of HIV/AIDS. The difference between the two age groups was not statistically significant (t = -0.55, df = 8 and *p* = 0.5989).

5.4.3.4 Perceived barrier

Majority (81%) of the young people in age group 15-19 years did not perceive any barrier in keeping the same sexual partner for a long time while majority (53%) in age group 20-25 years age group perceived barrier in keeping the same partner for a long time. There was no statistical significant difference among the two groups (t = -0.78, df = 8 and p = 0.4597).

Ninety one percent thought that buying condom is embarrasing so they perceived buying condom as a barrier in age group 15-19 while 81% in the age group 20-25 did not perceive any barrier in buying condom as being embarrasing. There was no statistical significance difference between them (t = -0.58, df = 8 and p = 0.5783).

All the young people in 20-25 years age group did not perceive any barrier in condom not being easy to use to 147 (98%) in age group 15-19 that did not perceive any barrier. There was no statistical significant difference between the two age groups (t = -0.51, df = 8 and p = 0.6242).

Majority of the young people (86%) in age group 20-25 and 84% in age group 15-19 years did not perceive any barrier in condom reducing the quality of sex so much that it is better not to use it at all. The difference between the two groups was not statistically significant (t = -0.66, df = 8 and p = 0.5295).

5.4.3.5 Cues to action

Ninety nine percent in age group 15-19 years to 92% in age group 20-25 years believed that one should think carefully before engaging into sexual relations. The remaining 1% in age group 15-25 was not sure. None of the young people responded negatively in age group 15-19 but 5 (5%) in age group 20-25 had negative attitude. There was no statistical significance difference between the two groups (t = -0.54, df = 8 and p = 0.6012). The findings are consistent with the findings by Lillie, Pulerwits and Curbow (2009:281) in their study among the Kenyan in-school Youths which revealed that majority said they would wait until the right time to have sex.

Most of the young people (98%) in age group 15-19 to 89% in 20-25 years age group believed that sexual intercourse is not the only way two people can get to know each other. There was no statistical significance difference between the two groups (t = -0.51, df = 8 and *p* = 0.6267).

5.4.3.6 Self efficacy

In age group 15-19, majority of them (82%) to 75% in age group 20-25 years believed they feel comfortable talking about abstinence . There was no statistical significance difference between the two groups (t = -0.74, df = 8 and *p* = 0.4814).

From the finding of this study, 36% young people in age group 15-19 years to 43% in age group 20-25 years believed that abstinence is not difficult to practice. The young people that did not believe in age group 15-19 were 33% to 40% in age group 20-25. In age group 15-19, 31% were not sure to 17% in age group 20-25 on whether it is difficult to practice abstinence or not. There was no statistical significance difference among the two groups (t = -1.88, df = 8 and *p* = 0.0967). The finding in age group 20-25 years is in line with the finding in a study in Lesotho by Morolong (2004:48) on attitudes of polytechnic students towards ñABCò strategy which found that 41.8% of the students aged 20-25 years chose abstinence as the best means of protection among other safe methods to prevent HIV/AIDS, they did not find abstinence diffficult to practice.

Majority young people (68%) in age group 15-19 did not have the confidence to postpone sexual relations until they are able to take responsibility for their actions whereas 50% of young people in age group 20-25 had the confidence to postpone sexual relations until they are able to take responsibility for their actions. There was no statistical significant difference between the two groups (t = -1.06, df = 8 and *p* = 0.3210).

According to the finding between the two different age groups, 66% young people in age group 15-19 to 64% in 20-25 years age group knew that it is not compulsory to be engaged in sexual activities. There was no statistical significance difference between the two groups (t = -1.05, df = 8 and *p* = 0.3247).

In age group 15-19, 49% to 45% in age group 20-25 had confidence to communicate with partner if they find out they have HIV/AIDS. The difference between the two groups was not statistical significant (t = -0.72, df = 8 and *p* = 0.4894).

All the respondents in age group 20-25 to 99% in 15-19 years age group had confidence to communicate with partner about HIV/AIDS. The remaining 1% in age group 15-19 was not sure. The difference between the two groups was not statistical significant (t = -0.54, df = 8 and *p* = 0.6045).

Majority of the young people (77%) in age group 15-19 did not have the confidence to discuss using condom with partner whereas 56% in age group 20-25 had confidence to communicate with partner about using condom. There was no statistical significance difference between the two groups (t = -0.86, df = 8 and *p* = 0.4141).

5.5 CONCLUSIONS

5.5.1 Perceived susceptibility

The young people were susceptible to HIV to some extent by believing that a regular partner can infect another with HIV/AIDS and also they would not prove their love by having sex without a condom but when they were asked if they could avoid sex by not using it to prove their love, they were not sure if they may or may not prove their love by having sex with their partners. On the other hand, they did not perceive themselves susceptible by believing that sex was not meant for only two trusted people. This was an indication that showed that these young people do not practice the ñABCò strategy.

5.5.2 Perceived severity

The young people perceived the seriousness of HIV/AIDS by knowing the worth of condom but when it came to the practice of using condom in steady relationship, their perception to the severity of the disease changed. They did not believe that condoms should be used in steady relationships and using condom in a steady relationship

indicated lack of trust. This showed that they knew the importance of ñABCò but they did not perceive the severity of HIV/AIDS by practicing the strategy.

5.5.3 Perceived benefit

The young people perceived the benefit of adopting ñABCò by believing that condom helps prevent HIV/AIDS, faithfulness is very important in a relationship and abstinence needs discipline and will power. They were neutral meaning majority were positive and negative that having sex with many people does not make sex more enjoyable.

5.5.4 Perceived barrier

They perceived barrier in buying condom as being embarrasing but they did not perceive condom not being easy to use as a barrier. They did not perceive any barrier in having same sexual partner for a long time boring and also no barrier in condom reducing the quality of sex so much that it is better not to use it at all.

5.6.5 Cues to action

The young peoplesô belief of thinking carefully before engaging into sex was very high and also sex not being the only way to know each other was also very high. The cue to action for these young people to change their attitude was very high.

5.5.6 Self efficacy

The young people had confidence to talk about abstinence and believed sexual activities are not compulsory. They had confidence to communication with partner about HIV/AIDS but when it came to more practical way of being self efficent, they did not believe that they could postpone their sexual relations until they are able to take responsibility for their actions and them being embarassed by discussing the use of condom with partner. They were positive and ambivalent about communication with partner about their positive HIV status if they had HIV/AIDS and neutral (positive and negative) about abstinence not being difficult to practice.

5.6 RECOMMENDATIONS

5.6.1 Recommendations from the findings

The young people should not only be information receivers but also be information givers. These young people should be encouraged to open up to discussions and try to share opinions about ñABCò strategy and HIV/AIDS to other people expecially their partners because some respondents were negative than others when it came to talking over HIV/AIDS or ñABCò with their partners. From the findings, 48% of young people believed that discussing using condom with someone is embarrassing. Another finding from the study revealed that 99 (42%) of the young people had ambivalent attitude that, if one contracts HIV/AIDS, one must talk about it to his or her partner. Peer and partner education should be supported in all educational insitutions as an important avenue for HIV/AIDS education, information and communication. Policy development should emphasize on open discussions and promotion of ñABCò

It is essential to increase awareness among these young people that unexpected sexual situations may occur either in casual or steady relationship and they should be trained to take preparatory actions. In this study 204 (83%) young people believed that the use of condom with a steady partner indicates lack of trust.

Since most of the young people found buying condom embarrassing, condoms should be made more accessable to these young people in their schools or where mostly they are found targeting mostly the young people. There should be expansion of the distribution of condom through the private sectors and peers. The findings in this study demonstrated that 154 (55%) of young people aged 15-25 years had negative attitude towards buying condom. People should be educated more on not looking down on these young people when they intend buying condoms by addressing provider attitude to help improve the quality of public sector provision.

There are many factors which should be considered when trying to instil safe behaviours to protect these young people from risk of infections like involvement, empowerment, self-confidence, capacity building, participation of these young people in all developmental initiatives and HIV/AIDS campaigns which would help them spread

the message very well like in this study, it was found that 72 (36%) of young people believed that having sex with many people makes sex more enjoyable so it is recommended that their involvement in developmental initiatives and campaign would improve their attitude. There is need to engage the young people in the fight against HIV/AIDS and not to design programmes on behalf of the youths. For any youth, a participatory approach should be warranted.

Young people have particular vulnerability and so there is need to work to empower these young people to effectively negotiate condom use. Majority 132 (48%) of the young people in the findings of this study had negative attitude discussing condom use with partner. Pragrammatic efforts are needed while continuing to target these young people, social marketing and other interventions need to be larger in scope, more diverse and bold, using mass media, interpersonal techniques, newspapers written by youth for youth and large-scale drama events.

5.6.2 Recommendations for further research.

There is need to conduct this research in other geographic areas prior to generalisation of the research results to all the young people in Botswana.

There is need to conduct research on the challenges the young people face with their partners on trying to adhere to ñABCò strategy. In particular, some young people had difficulty remaining abstinent and some young females in male-dominated relationships are frequently unable to negotiaite condom use, let alone abstinence. Some associate condoms with prosmiscuity or lack of trust in Francistown, Botswana.

There is need to conduct research to evaluate the quality of HIV/AIDS preventive programmes, its effectiveness and successes in schools in Francistown.

5.7 LIMITATIONS

The study was conducted in one city of Botswana (Francistown) and the findings can therefore not be generalised to other cities of Botswana.

Although most of the young people are found in schools, out of school young people were not studied, the findings cannot be generalised to all young people in Francistown.

Data were collected by using self administered questionnaires. Although the researcher and HIV cordinators were available to answer questions. It was possible that some respondents might have misinterpreted some questions.

Not all the questionnaires that were distributed were returned. The missing questionnaires may or may not have affected the result of the study.

There was no separate register for the males and females in order for the researcher to carry out a random sampling among them, the chances of not getting equal number of males to be compared with equal number of females were high and since the study involved comparison of males and females, the findings may not be true reflection of the males and females attitude.

5.8 CONCLUDING REMARK

HIV/AIDS poses a major public problem and young people aged 15-25 years have the highest rate of infection. The young people in Francistown, Botswana have high rate of HIV/AIDS and Botswana has the highest rate in sub Sahara Africa. It was not easy for some of the young people in Francistown to sustain changes in sexual behaviour. In particular, some young people had difficulty remaining abstinent. Some associate condoms with prosmiscuity or lack of trust.

Attitudes of young people towards ñABCò strategy were important to determine; in order to know why HIV/AIDS was increasing among them in Francistown, Botswana.

The study revealed various attitudes towards ñABCò strategy among young people aged 15-25 years in Francistown, Botswana. Although these young people displayed familarity with the knowledge of ñABCò and how important it was to abstain, use condom

and be faithful to relationships, ignorance of some basic facts on the topic prevailed especially regarding them postponing sexual relations until they were responsible to take responsibility for their actions, them proving their love by having sex with their partners if they loved their partners, buying condom being embarrassing, use of condom with steady partner indicating lack of trust. This emphasises the need for continued promotion of education especially instilling self confidence among these young people.

In general to the HBM used in this study. Young people did not perceive the seriousness of the disease when it came to the practice of ñABCò. Young peopleôs cue to action was very high but there confidence to live with the practice of the ñABCò strategy was low. The knew the benefits of adopting positive attitude towards ñABCò strategy but perceived barrier in buying condom which they found embarrassing and abstinence not being easy to practice. The differences between the two age groups, 15-19 and 20-25 years were not statistically significant. There were also no statistically significant differences between males and females.

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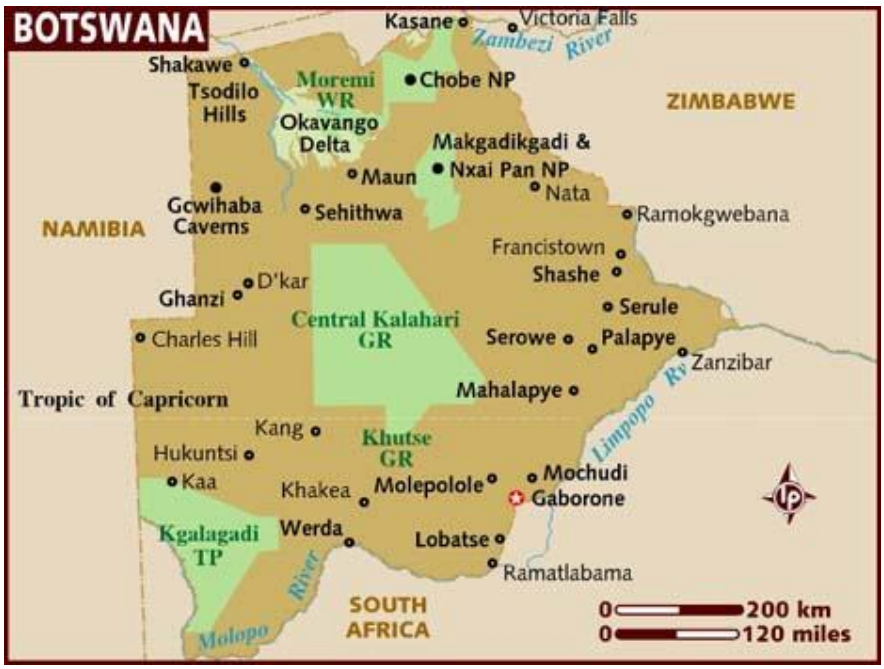
ANNEXURE A

MAP OF BOTSWANA


BOTSWANA
Kasane
Victoria Falls
Zambezi River
Shakawe
Moremi WR
Chobe NP
Tsodilo Hills
Okavango Delta
ZIMBABWE
Makgadikgadi &
Nxai Pan NP
Maun
Nata
Gcwihaba Caverns
Sehithwa
Ramokgwebana
NAMIBIA
Francistown
Shashe
D'kar
Ghanzi
Serule
Central Kalahari GR
Charles Hill
Serowe
Palapye
Zanzibar
Limpopo Rv
Tropic of Capricorn
Mahalapye
Kang
Khutse GR
Hukuntsi
Kaa
Khakea
Molepolole
Mochudi
Gaborone
Kgalagadi TP
Werda
Lobatse
Ramatlabama
Molopo River
SOUTH AFRICA
0 200 km
0 120 miles

ANNEXURE B

CLEARANCE CERTIFICATE FROM UNIVERSITY OF SOUTH AFRICA (UNISA)

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date of meeting: **12 January 2009** Project No: **35921153**

Project Title: **Attitudes of young people aged 15-25 years towards "ABC" strategy in the prevention of HIV/AIDS in Francistown, Botswana**

Researcher: **Ms J Ezeahurukwe**

Supervisor/Promoter: **Mrs ME Chauke**

Joint Supervisor/Joint Promoter: **Mrs EN Monama**

Department: **Health Studies**

Degree: MA (Public Health)

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Date: **13 January 2009**

Prof L de Villiers
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES

Prof MC Bezuidenhout
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE C

PERMISSION LETTER FROM THE MINISTRY OF HEALTH

Telephone: (267) 363200
FAX (267) 353100
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REPUBLIC OF BOTSWANA

REFERENCE NO: PPME 13/18/1 PS IV (67) 13 October 2009

Health Research and Development Division

Notification of IRB Review: New application

Mrs Ezeahurukwe Julia
P.O. Box 1770
Francistown

Protocol Title:	**ATTITUDES OF YOUNG PEOPLE AGED 15-25 YEARS TOWARDS "ABC" STRATEGY IN THE PREVENTION OF HIV/AIDS IN FRANCISTOWN, BOTSWANA**
HRU Protocol Number:	HRU 00561
Sponsor:	N/A
HRU Review Date:	12 October, 2009
HRU Expiration Date:	11 October, 2010
HRU Review Type:	HRU reviewed
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Dear Mrs Ezeahurukwe

Thank you for submitting a new Application for the above referenced Protocol.
This approval includes the following:

1. Application form
2. Proposal
3. Consent form

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel +267-3914467 or Mary Kasule at mkasule@gov.bw or marykasule@gmail.com Tel: +267-3632466

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: www.moh.gov.bw or can be requested via e- mail from Mr. Kgomotso Motlhanka, e-mail address: kmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

Do not hesitate to contact us if you have any questions. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

P. Khulumani
For Permanent Secretary

PERMANENT SECRETARY
MINISTRY OF HEALTH
RESEARCH UNIT
13 OCT 2009
P/BAG 0038
GABORONE
REPUBLIC OF BOTSWANA

ANNEXURE D

PERMISSION LETTER FROM THE MINISTRY OF EDUCATION

SAVINGRAM

FROM: Chief Education Officer
Ministry of Education & Skills
Development (North)

G. M. Pitso for/CEO

NORTH REGION EDUCATION OFFICE
(SECONDARY)
17 FEB 2009
PRIVATE BAG ... FRANCISTOWN
TEL: 2160... FAX: 2160...

TEL: 2415623/2413181

FAX: 2410838

TO: School Heads
Mater Spei College
Francistown Senior Secondary School
Setlalekgosi CJSS

REF: RSE 10/34 VI (136) 17th February 2009

RE: RESEARCH ON HIV & AIDS

The bearer **EZEAHURUKWE JULIA** has been authorised by the Regional Education Office to conduct research on HIV/AIDS in your learning institutions.

Please afford her the necessary support.

ANNEXURE E

PERMISSION LETTER FROM MATER SPEI COLLEGE

MATER SPEI COLLEGE

A Government Aided Catholic Institution

Reference: MSC/E/15/ II

Private Mail Bag F12
Francistown
Botswana

2nd March 2009

Julia Ezeahurukwe
P O Box 1770
Francistown

Dear Julia Ezeahurukwe

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

We are in receipt of your letter dated 19th January 2009, in which you request to conduct a research study.

We wish to inform you that your request has been granted. Please contact our HIV/AIDS Coordinator for final arrangements.

Thank you.

Yours faithfully

DEPUTY HEADMASTER
★ 2009 -03- 12 ★
MATER SPEI COLLEGE
PRIVATE BAG F12, FRANCISTOWN

J Munyera
Deputy School Head

ANNEXURE F

PERMISSION LETTER FROM SETLAKGOSI CJSS

Tel: 2412766
Fax: 2410176
E-mail:

REPUBLIC OF BOTSWANA

Setlalekgosi Community
Junior Secondary School
Private Bag T39
Tatitown

20th February 2009

Ezeahurukwe Julia
Our Lady of the Desert catholic Church
P O Box 1770
Francistown

RE: RESEARCH ON HIV & AIDS

This letter is to inform you, EZEAHURUKWE JULIA that your application for conducting a research on HIV/AIDS in our School has been successful.

Hoping that your research will be a success.

Thank you

Yours faithfully

Ms S L Mbenge
HIV/AIDS COORDINATOR

ANNEXURE G

PERMISSION LETTER FROM FRANCISTOWN SENIOR SECONDARY SCHOOL

Aerodrome, Domboshaba Road
Email: fsss@inet.co.bw

REPUBLIC OF BOTSWANA

Francistown Senior Secondary School
Private Bag 14
Francistown
Botswana

Tel. 2413812, Fax. 2413033

5 March 2009

Julia Ezeahurukwe
P. O. Box 1770
Francistown

Dear Miss Julia Ezeahurukwe

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

With reference to your letter received which was dated on the 30th January 2009, we hereby accept that you can conduct your research in our school.

Thank you.

Yours faithfully

O. Othusitse
School Head

FRANCISTOWN SENIOR SECONDARY SCHOOL HEAD
2009 -03- 05
PRIVATE BAG 14, FRANCISTOWN
TEL: 2413812 • FAX: 2413033

ANNEXURE H

PERMISSION LETTER FROM BA ISAGO UNIVERSITY COLLEGE

BA ISAGO UNIVERSITY COLLEGE
GABORONE CAMPUS
BAGAKA HOUSE, Plot 168, Gaborone International Commerce Park,
Private Bag 149, Suite # 268, Kgale View Postnet, Gaborone, Botswana
Tel: (+267) 3957744 Fax: (+267) 3957709 Email: enquiries@baisago.co.bw

FRANCISTOWN CAMPUS
Haskins Building, Plot No 1602/3, off Sam Nujoma Road, Light Industrial Site, Private Bag F238, Francistown, Botswana
Tel: (267) 2418780 Fax: (267) 2418778 Email: enquiriesftown@baisago.co.bw
Co. Reg. No 2001 / 4109

Est. in 2001

UNISA

25 February 2009

Mrs Julia Eheahurukwe

P. O. Box 1770

Francistown

Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

This letter refers to your request for permission to conduct a research study at Ba isago University, Francistown campus, dated the 19th January 2009 and the subsequent meeting held on the 24th February 2009 with the Campus Coordinator and the student support services office.

We are grateful to extend permission to you for the purpose of your research study into "the attitudes of young people aged between 15-25 years towards "ABC" strategy in the prevention of HIV/AIDS in Francistown. We are confident you will adhere to the prescribed code of ethics and conduct as laid out by the University of South Africa.

Kindly liaise with the student support services office in the conduct of your project or if you need any assistance.

Yours Faithfully

T. D. Molefi

Student Support Services

BA ISAGO UNIVERSITY COLLEGE (PTY) LTD
P/BAG F238, FRANCISTOWN
TEL: 2418780 FAX: 2418778
"A UNISA OFFICIAL TUITION CENTRE"

ANNEXURE I

PERMISSION LETTER FROM MARANG SUPER SPAR

SPAR

TSETSENG INVESTMENTS (PTY) LTD
MARANG SUPER SPAR
POX 10423 NZANO CENTRE
FRANCISTOWN
Ph (09267) 2410335
Fax (09267) 2410334
E-mail ftown

T/A: FRANISTOWN SUPERSPAR
Bamangwato Spar
Broadhurst Spar
Delta Spar
Kasane Spar
Kgale Superspar
Mahalapye Spar
Marang Superspar
Mochudi Spar
Molepolole Spar
NzanoSuperspar
Orapa Spar
Palapye Spar
Phakalane Spar
Safari Spar
Serowe Spar
VillageSpar

Date: 01/04/2009

JULIA EZEAHURUKWE
PO BOX 1770
FRANCISTOWN

REF: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

WE REFER TO YOUR LETTER ADDRESSED TO US REQUESTING PERMISSION TO CARRY OUT A RESEARCH STUDY WITH OUR YOUTH EMPLOYEES.

YOU ARE THEREFORE INFORMED THAT WE GRANT YOU PERMISSION TO CARRY OUT THE RESEARCH ABOVE.

PLEASE ARRANGE WITH US SO THAT WE CAN MAKE IT POSSIBLE FOR OUR STAFF MEMBERS TO ATTEND TO YOU.

WE THANK YOU FOR YOUR COOPERATION

THANKS
MOHUTSIWA DIKGAKOLOLO (MR)
01/04/09
(STORE MANAGER)

SETSENG INVESTMENTS (PTY) LTD
MARANG SUPER SPAR
P.O. BOX 10423 FRANCISTOWN
TEL/FAX: 2410310/11
VAT REG NO. C0073710111 2

ANNEXURE J

CONSENT LETTER

CONSENT OF RESPONDENTS/PARENTS

Ié .., hereby give my personal/my child consent to participate in the research project titled " Attitudes of young people aged 15-25 years towards ñABCòstrategy in the prevention of HIV/AIDS in Francistown", as a research project by Ezeahurukwe Julia at the Department of Health Studies, Unisa. I understand that the information will be treated with the utmost confidentiality and that my/ my child anonymity will be protected.

I have read through the information letter, which explains the research purpose and the objectives of the research and understand that I/ my child have the right to withdraw at any time without any fear of coercion or emotional black mail.

I also understand that I have a right to insight into all the proceedings of the research and that I can contact the researcher about anything to the research.

SIGNATUREé é é é é é é é é é é é é é é é é é (Participant/Parent)

Date:é é é é é é é é é é é é é é é é é é .

ANNEXURE K

QUESTIONNAIRE

My name is Ezeahurukwe Julia, a student of UNISA studying public health in the department of health studies. I am required to do a research in fulfillment for the degree of Master of Arts in Public Health. The title of my research is ATTITUDES OF YOUNG PEOPLE AGED 15 – 25 YEARS TOWARDS THE "ABC" STRATEGY IN THE PREVENTION OF HIV/AIDS IN FRANCISTOWN, BOTSWANA. The purpose of this study is to describe the attitudes of young people aged 15-25 years towards "ABC" strategy to prevent HIV/AIDS in Francistown: Botswana. The findings from this study will provide insight into the attitudes of young people aged 15 – 25 years towards "ABC" strategy so that future programs focus not only on information giving but also on changing attitudes. Your voluntary participation in this study is appreciated. You have the right to voluntarily decide to participate in this study without any risk of incurring any penalty and withdrawal from the study is allowed. You will not be linked to any completed questionnaire. The information collected will be used for the purpose of the study and would be made available to you if you requested it. There is no benefit for participating in the study.

SECTION A: SOCIAL DEMOGRAPHIC PROFILE

INSTRUCTIONS

- **Please answer all questions in all the sections.**
- **Your name and identification number is not needed. It means that you can never be traced or followed**
- **Please give answers honestly**
- **Try and return the questionnaire within 12 hours of receipt.**
- **Please mark the appropriate box with an tick (√) for the answers in section A**

AGE in years at last birthday ----------

A1

15 ï 19 yrs		1
20 ï 25yrs		2

GENDER

A2

Male		1
Female		2

MARITAL STATUS **A3**

Married		1
Single		2
Widow		3
Divorced		4

DO YOU LIVE IN FRANCISTOWN AT THE MOMENT **A4**

Yes		1
No		2

DO YOU ATTEND SCHOOL? **A5**

Yes		1
No		2

IF YES, WHAT IS THE LEVEL OF EDUCATION? **A6**

Junior secondary (form one to form three)		1
Senior secondary (form four to form five)		2
Higher education institution		3

IF NO, ARE YOU EMPLOYED? **A7**

Yes		
No		

- **Please indicate to which extend you agree or disagree with the following statements by marking the appropriate box with an X on the scale in section B, C and section D**

SECTION B : ATTITUDE TOWARDS ABSTINENCE

Agreement/disagreement scale

		Strongly agree	Agree	Disagree	Strongly disagree	Not Sure	Office use
1	Abstinence is not difficult to practice						**B1**
2	It is not compulsory to be engaged in sexual activities						**B2**
3	I feel comfortable talking about abstinence						**B3**
4	Abstinence needs discipline and willpower						**B4**
5	Sexual intercourse is not the only way two people can get to know each other						**B5**
6	Before engaging into sexual relation one should think about it carefully						**B6**
7	It is possible to postpone sexual relations until a person is able to take responsibility for his or her action						**B7**
8	If I love my partner I will not prove my love for him/her by having sex with him/her						**B8**

SECTION C: ATTITUDE TOWARDS FAITHFULNESS

		Strongly agree	Agree	Disagree	Strongly disagree	Not sure	Office use
1	Faithfulness is very important in a relationship						**C1**
2	It is possible to contract HIV/AIDS from a regular partner						**C2**
3	If a person finds out that he or she has HIV/AIDS he or she has to talk about it with his or her partner						**C3**
4	It is important that one can talk with his or her partner about HIV/AIDS						**C4**
5	Only the two people who trust each other completely should have sexual relations						**C5**
6	It is boring to have the same sexual partner for a long time						**C6**
7	Having sex with many people does not makes sex more enjoyable						**C7**

SECTION D: ATTITUDE TOWARD CONDOM

		Strongly agree	Agree	Disagree	Strongly disagree	Not Sure	Office use
1	Using condom does not help to prevent HIV/AIDS						**D1**
2	If I love my partner I will prove my love for him/her by having sex with him/her without a condom						**D2**
3	Buying condom is embarrassing						**D3**
4	Using condom to prevent the spread of HIV/AIDS is more trouble than its worth						**D4**
5	Condoms are not easy to use						**D5**
6	Discussing using condom with someone is not embarrassing						**D6**
7	Condom reduces the quality of sex so much that it is better not to use it at all						**D7**
8	Condoms should be used in casual encounters and not in steady relationships.						**D8**
9	Use of condom with a steady partner indicates lack of trust						**D9**

Thank you for your participation