

**THE ASSOCIATION BETWEEN FAMILY STRUCTURE AND SEXUAL
RISK FACTORS RELATED TO HIV INFECTION OF YOUNG PEOPLE
[AGED 14-24] IN GABORONE [BOTSWANA]**

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DECLARATION

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SUMMARY

Purpose of the Study

The purpose of this study was to find out whether there is an association between family structure (a well-structured family or a non-structured family) and sexual risk factors related to HIV infection of youths aged 14-24 [inclusive] in Gaborone, Botswana.

Research Design

A descriptive research design using quantitative approach was used in this study.

Data Collection

Data was collected through questionnaires handed to the respondents to fill and return the responses back to the researcher. Youths from Old Naledi location, University of Botswana and Gaborone Senior Secondary School served as study population.

Findings

The results showed there was no significant association between family structure family and the sexual risk factors related to HIV infection of youths aged 14-24 [inclusive]. Nevertheless, the results showed that as young people get older, they indulge in high-risk behaviours related to HIV infection, such as having sex under the influence of alcohol, having multiple sexual partners and having sex in exchange for money.

Conclusion

The findings have shown that the youth in general are at high risk of contracting HIV infection. A high number of them are sexually active, and therefore it is suggested that they be encouraged to be more pro-active in order to prevent HIV infection or infection with other sexually transmitted diseases.

OPSOMMING

Doelwit van die Studie

Die doel van hierdie studie was om uit te vind of daar 'n verband is tussen familiestruktuur (goed-gestruktueerde familiestruktuur of nie-gestruktueerde familiestruktuur) en seksuele risiko faktore wat verband hou met MIV-oordrag onder jongmense tussen 14 en 24 jaar (inklusief) in Gaborone (Botswana).

Navorsingsontwerp

'n Beskrywende navorsingsontwerp met 'n kwantitatiewe aanslag is gebruik.

Data Versameling

Data is ingesamel deur middel van vraelyste. Jongmense van die Naledi-omgewing, Universiteit van Botswana en Gaborone Senior Sekondêre Skool het as studiepopulasie gedien.

Resultate

Die resultate het gewys dat daar geen betekenisvolle verband was tussen familiestruktuur (goed-gestruktueerde familiestruktuur of nie-gestruktueerde familiestruktuur) en seksuele risiko faktore wat verband hou met MIV-oordrag onder jongmense tussen 14 en 24 jaar (inklusief) in Gaborone nie. Die resultate het egter aangedui dat, soos jongmense ouer word, hulle hoë risiko seksuele gedrag wat verband hou met MIV-oordrag begin vertoon. Voorbeelde van hoë risiko seksuele gedrag wat verband hou met MIV-oordrag, sluit onder andere in seksuele omgang onder die invloed van alkohol, veelvuldige seksuele verhoudings en seks vir geld.

Gevolgtrekking

Die resultate het gewys dat jongmense oor die algemeen 'n groot kans staan om met MIV geïnfecteer te word. Baie jongmense is seksueel aktief, en die aanbeveling is dat hulle aangemoedig moet word om pro-aktief op te tree ten einde infeksie van MIV of enige ander seksueel oordraagbare siekte te voorkom.

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Explanation of Terms

Young person

A young person could be an adolescent. Adolescence is a period of transition from childhood to adulthood characterised by physical, social, psychological and biological changes. World Health Organisation (WHO) defines the period as ranging from 10-19 years. While in Botswana the period has been extended from 10-24 years for the purpose of programmes towards the youth (Ministry of Health, 2002). In this paper, the terms 'adolescence' and 'youth' or young people shall be used interchangeably with an age limit of 14-24 [both limits inclusive].

Family

A family is group of people that are related by blood, affinity or co-residence (Webster Dictionary). One of the primary roles of a family is to produce individuals biologically or socially. In other words a family has as one of its core responsibilities to locate children socially and play a major role in their enculturation and socialisation (Dolwick, 2009). A family structure therefore is how a family is organised. According to Dolwick, family structure is considered a traditional family support system involving two married individuals providing care and stability for their biological offspring's. Collins Concise dictionary describes family as a primary social group consisting of parents and their offspring. Generally a family extends form outward from the individual through linkages of blood and marriage. It can be based on genetic ties or social ties and often implies economic rights and responsibilities (Garbarino, 1992). Whoever is present in the family makes the structure of that family. In this study, whether the parents are married or not shall not be considered. Rather the presence of both parents whether married or unmarried; hence one parent present in a family raising children single handily will be termed non-structured family and a family with both parents raising children together will be termed well-structured in this work.

Social Factors

According to Collins dictionary, social is defined as relating to or having the purpose of promoting companionship or communal activities. The term 'Social' refers to a characteristic of living organisms, human beings in particular. It also refers to the

interaction of organisms with other organisms and to their collective co-existence, irrespective of whether they are aware of it or not, or whether the interaction is voluntary or involuntary (Dolwick, 2009).

A well-structured family

This type of family, according to the researcher is termed the ideal hence the name well-structured. A common belief or perception among people is that what characterises this type of family structure is usually stability, either both or one parents is working to bring up the children, educating them in ways they should take care of themselves. In this family (not always the case), children are seldom left to fend for themselves.

A non-structured family

According to the researcher in this family there is one parent present; either a father or mother could be heading the family or none of them could be present to give proper guidance and leadership. In this type of families, the common perception and thinking among people is that there is instability, one parent bring children single handed with limited resources, he /she educate children in ways they should face life, but with little influence. Children are often left to fend for themselves while one of the parents parent spend most time at workplace (if any) or there is just no parent.

Human Immunodeficiency Virus Infection

This describes the state of being found with HI virus in one's body system

Vulnerability to HIV infection

Vulnerable means capable of being physically or emotionally wounded or hurt (Collins Concise Dictionary). Therefore vulnerability to HIV infection means increasing ones chance or being prone to be infected with HIV.

Acronyms

AIDS	- Acquired Immunodeficiency Syndrome
OAU	- Organisation of African Unity
BAIS	- Botswana AIDS Impact Survey
CSO	- Central Statistics Office
HIV	- Human Immunodeficiency Virus
MoH	- Ministry of Health
NACA	- National AIDS Coordinating Agency
UNESCO	- United Nations Educational Scientific and Cultural Organisation
UNAIDS	- United Nations Agency for HIV/AIDS
UNDP	- United Nations Development Programme
UN	- United Nations
WHO	- World Health Organisation

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CHAPTER 1: INTRODUCTION

1.1 BACKGROUND/RATIONALE OF THE STUDY

Botswana is one of the most affected countries by HIV/AIDS pandemic and has once recorded one of the world's highest prevalence rates of about 38% (NACA, 2002). Although HIV has affected almost everyone in the country, there are certain groups of people that are more affected by the virus than others. These groups account for majority of people living with HIV. The groups may include the women, the young people, the poor, men having sex with men and commercial sex workers.

Groups such as these have factors that predispose them to infection in many diverse ways. Some of the factors that could predispose individuals to HIV infection are economic, cultural, behavioural, or an interrelatedness of these factors. The youth, as one of the most populations at risk, are the main focus of this paper.

There are many factors that play a significant role in HIV infection among the youth. One of the main drivers of HIV acquisition among young people in Botswana seems to be early age of sexual debut. The age of sexual debut is around 14-16, and teenage pregnancy continues to be one of the most inflicting problems even today. In most cases the age for sexual debut for young females is lower than that of their male counterparts – which make the female young people even more at risk of contracting the virus.

There also seems to be a common practice of giving young girls into marriage that is encouraged by a social expectation for men to be providers and for women to depend solely on men for resources. Young women are therefore stripped of the power to negotiate safe sex in the fear of losing the sexual partners whom are viewed as bread winners in their lives. In some instances young girls may get involved in casual sexual relationships with older men in exchange for money and material possessions thereby exposing themselves even further.

One other common practice among young people in Botswana seems to be indulgence in unprotected sex. This could be unprotected sex with someone with unknown HIV status, or with a new partner or in a newly formed relationship. In many cases it seems people tend to take a shorter time to presume and 'trust' that their partners are HIV negative and then indulge in unprotected sex. Moreover, these sexual relationships seem to last for a relatively short period of time. Therefore one individual could have an average of about two to three sexual relationships in a period of one year. This could also be a contributing factor to the many new infections in the country and perhaps the increase in the number of people being infected by the virus every year.

The practice of multiple concurrent partners in Botswana seems to be common among young people. This is usually common among men with the social expectation that they (men) are 'socially and culturally acceptable' to have more than one sexual partner as proof of manhood. On the other hand, women have also joined in the practise for various reasons. Such reasons could be economic, mischievous acts of teenage hood, or habitual sexual acts under the influence of alcohol. This 'multiple concurrent partners practice' creates a hub of sexual networks that continually transmit the virus within multiple sections of the society at the same time.

These networks can also continue to be responsible or give birth to new infections as sexual relationships are formed and broken within a society. Even after a behavioural change, these networks can continue to be viable reservoirs for possible transmission of the virus to the uninfected. This is particularly true for the youth as they engage in sexual relations in the later stages of their lives as they engage in intergenerational sexual relations.

Testing, as one fundamental step to preventing HIV transmission, does not always seem to come easy to young people. To them, HIV diagnosis may be associated with shame, fear of death, and emotional torture. Some young people would rather 'prefer' not to test than to go through the emotional pain and social discrimination that is associated with knowing ones' HIV status. This ignorance could suggest that there may be sexually active individuals who might be HIV infected and continue to spread

the virus without knowing or without taking full responsibility of protecting their sexual partners.

From the above, the youth therefore constantly find themselves at high risk of HIV infection. Factors include – but are not limited to – low or no use of condoms, use of alcohol, substance abuse and sex sale. These risky behaviours are usually associated with the adolescent stage in which the youth undergo.

Early sexual debut, intergenerational sexual relationships, unprotected sex with a partner of unknown status, having sex for money, having multiple sexual partners either concurrently or in spaces of time, fear of testing and knowing ones status, low and improper use of condom and having sex under the influence of alcohol are a few reasons that are commonly known and understood to increase the vulnerability of people to HIV infection.

There are also other complexities that seem to be ‘in built’ in societies that could be responsible for driving the spread of HIV. Some of these factors are societal expectations, socio-cultural, family norms, the type or structure of family one is raised in, moral expectations, religion, poverty and others. These behaviours and factors may be ‘deeply in graved’ within the communities and families in which the youth are raised and seldom blamed for factors increasing the vulnerability of HIV among the youth.

In this paper, the researcher will argue that besides the known risk factors associated with HIV infection discussed earlier; the type of family structure one is brought up in could also be a factor that may increase susceptibility to HIV infection.

Modernisation and other socio-cultural changes – just to list a few – have effects on family structure that can be blamed for increased vulnerability of the youth today. As stated earlier on, the loss of adults to AIDS has a significant effect on the youth of Botswana: an estimated 95,000 children have lost at least one parent to the epidemic (UNESCO, 2009). One of these effects could be increased vulnerability to HIV infection.

Single parent homes in Botswana are common; hence more children are from families with only one parent. With more children born to unmarried couples, which in most cases do not raise children together, there is high probability that most of them could lack proper guidance and leadership from their parents or one of their parents who is not present in their lives.

The researcher hypothesises that youth growing up in families that are broken (non-structured families) where the head could be either one parent, or grandparent, or child headed family) would be more vulnerable to HIV than young people raised in well-structured families (structured families defined as having both parents: mother and father raising children together). This paper thus seeks to focus on the family structure as social factor that may play a role in pre-disposing the youth to HIV infection.

1.2 BOTSWANA AND HIV INFECTION

1.2.1 Population Structure

Botswana's population is estimated to be 1.9 million people. Most of the people are concentrated in the eastern part of the country. Botswana is ethnically, linguistically and religiously homogeneous with nearly 70% identifying themselves as Christians (BAIS III, 2008). The country has a relatively young population structure, with about 60% of the approximately 1.8 million people aged less than 45 years of age (NACA, 2002). The structure of the population and the growth rate continue to be altered by the impact of the HIV/AIDS pandemic.

1.2.2 HIV/AIDS

In 2001, Botswana had the highest rates of HIV in the world, with estimates as high as 40% of the adults (Marlink & Kanki, 2009). Considering the fact that Botswana's population is below 2 million, the epidemic was at alarming rate. Today, the country has an adult prevalence rate of 17.6% (BAIS III, 2008). The youth aged 15-24 account for about 19.6% of all people living with HIV and AIDS country wide (BAIS III, 2008). This statistic suggests that the young people are greatly affected by the AIDS pandemic.

1.2.3 Future Impact of HIV/AIDS

UNDP (2001) estimated that if nothing was done to halt the epidemic, a third of the population could die leaving the very old and the very young in the population today. Life expectancy at birth fell from 65 years in 1990-1995 to less than 40 years in 2000-2005, a figure about 28 years lower than it would have been without AIDS (United Nations, 2004). The loss of adults in their productive years has serious economic implication with families being pushed into abject poverty through the cost of HIV and AIDS medical care, and subsequently the loss of breadwinners in families (NACA, 2005).

1.3 RESEARCH PROBLEM

The Botswana youth are generally knowledgeable on HIV/AIDS issues: A recent Botswana AIDS Impact Survey III (BAIS III, 2008) results show that among the youth aged 15-24 years, about 43% correctly identified ways of preventing the sexual transmission of HIV namely: (1) healthy persons can have HIV, (2) correct use of condom each time they have sex, (3) having one uninfected sexual partner and (4) at the same time they reject major misconceptions about HIV transmission or prevention particularly that people can get HIV through mosquito bite and/or witchcraft. Following from this, one may ask: Why then do the youth aged 15-24 account for about 19.6% of all people living with HIV and AIDS countrywide?

The loss of adults to AIDS had a significant effect on the youth of Botswana: An estimated 95,000 children have lost at least one parent to the epidemic (UNAIDS, 2008). It is problematic for these children to access good education or attends school as the family structure has been weakened by AIDS where children or youth may find themselves caring for their sick parents or taking care of their siblings. This finding can be viewed as evidence in support of the intended research on the role that family structure plays in terms of predisposing youths to the sexual risk factors associated with HIV infection. Who gives proper leadership and guidance to young people about risky behaviours or non-risky behaviours or practices where family structures have been weakened as a result of AIDS?

1.4 RESEARCH QUESTION

When conducting this study, the researcher will work towards answering this question:

Is there a difference between well-structured and non-structured families in terms of predisposing the youth in Gaborone to certain sexual risk factors associated with HIV infection?

Some of the further issues that will be explored are the following:

- Are young people from well-structured families or non-structured families more vulnerable to HIV infection?
- Are young people from non-structured families more involved in risky behaviours than young people from well-structured families?
- Are young people from non-structured families more involved in sex sale than young people from well-structured families?
- At what age do the youth in Gaborone start sexual relationships?

1.5 RESEARCH HYPOTHESIS

H0: There is no difference between well-structured and non-structured families in terms of predisposing youths to certain sexual risk factors associated with HIV infection in Gaborone (null hypothesis).

H1: There is a difference between well-structured and non-structured families in terms of predisposing youths to certain sexual risk factors associated with HIV infection in Gaborone (alternative hypothesis).

1.6 AIMS AND OBJECTIVES

The study aims and objectives are:

- To determine the different family structures that exist among youth aged 14-24 in Gaborone;
- To determine the sexual risk factors associated with HIV/AIDS of young people aged 14-24 in Gaborone;
- In order to understand the difference (if any) between well-structured and non-structured families in terms of predisposing youths to certain sexual risk factors associated with HIV infection in Gaborone.

1.7 STUDY JUSTIFICATION

This study may be important because young people are a priority group in the fight against HIV. The study may be of benefit to the youth to reduce incidence rate within this group. The estimated incidence rate in Botswana for the youth at age group 15-24 is around 3.92 %, a little higher than the national incidence rate, which is 2.89%. The HIV prevalence rate trend for Botswana begins to increase from ages 15-19 and 20-24. Although the incidence rate of this group is not the highest of all age groups, it marks a sharp increase from the previous age groups (BAIS III, 2008). This could be primarily because of the different factors that predominantly affect the youth as they approach adulthood hence the significance of this study.

This study may contribute to the knowledge on how certain social factors, particularly family structure, affect the knowledge and sexual practices of this age group. This age group is an important group to protect from the HIV epidemic, as they are the future of the country. Information on risk factors is important in developing effective campaigns and programs designed to protect and prevent the spread of the HIV pandemic. This study has a potential to feed such campaigns, programs and policies.

The study may benefit the youth in general: those who belong to age group of 15-24 and beyond. The younger age group may also benefit because the determinants that tend to drive this pandemic can be avoided or dealt with at a younger age hence decrease chances of HIV infection earlier. Determining these factors will educate the youth within the target group to be aware of such and avoid infection. The study may also be of importance to the planners and the implementers of AIDS programmes as

they will specifically plan for this group with its specific needs and challenges in mind.

The youth in Botswana start sexual relations at around the age of 15 and in some instances even younger, hence the need for the study. As discussed earlier, many young people aged 15-24 know how to prevent HIV transmission, yet HIV prevalence among this group is estimated to be 16% (Botswana AIDS impact Survey III, 2008). This age group has a great potential in changing the trend/course of the AIDS pandemic and a hope for an HIV free generation. Identifying the social obstacles or factors that drive the high prevalence within this group can create and expand opportunities for solutions that are relevant. Therefore, identifying additional factors that predispose young people to HIV infection, like the role of family structure, is important to pursue.

The impact of the pandemic on young people may be greatly reduced when the dynamics of the spread of HIV and the quality of life of those most affected and infected by the pandemic are understood comprehensively in terms of the role that family structure plays. Important action points can be easily identified and be put in place when right problems are identified with this group.

According to UNAIDS/WHO (2010), among young people in 15 of the most severely affected countries, HIV prevalence has fallen by more than 25% as these young people have adopted safer sexual practices. Similar to treatment access, the room for continued improvement on this success is great. This suggests that reduction of HIV transmission among young people – also in Botswana – is possible when the relevant strategies are in place.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Literature review refers to any investigation, whatever the scale that involves what other people have written about the area of interest, gathering information to support or refute your arguments and writing about the findings (Bell, 1999).

According to MoH (2002), young people in Botswana are vulnerable to substance abuse, delinquent behaviour, depression, suicide, sexual abuse, and taking sexual risk resulting in unplanned pregnancy and STD/HIV transmission. HIV infection was relatively high then among youth aged 15-24, and teenage pregnancy rate was approximately 16 % (MoH, 2002). Studies have pointed to underprivileged families or children from such families as vulnerable to HIV infection. This relationship between HIV infection and social background for youth has been linked with, among other, low economic status, poor or risky features of culture and traditions (UNAIDS, 2008).

The rest of this chapter will entail a discussion around the global update on HIV/AIDS and youth, the role of family structure and elaborating on certain sexual risk factors associated with HIV/AIDS infection. These topics form part of the theme that will be researched further as part of this thesis.

2.2 GLOBAL UPDATE ON HIV/AIDS AND YOUTH

Young people are more vulnerable to HIV/AIDS than older people. According to UNAIDS (2009), over 60 million around the world are infected with the virus, and half of this number became infected between the ages 15-24. A survey by USAID in 2009 also reports 12 million of youth living with the virus. This numbers show that young people are particularly affected by the virus.

Since the inception of the epidemic, more than 20 million African have died and 12 million have been orphaned as a result of HIV/AIDS (NACA, 2005). According to

this survey, the hardest hit age groups are those in the prime of their lives (The World Bank, Chilisa et al & Kelly 2001, as quoted by NACA, 2005). This suggests that most families are affected (either one or both parents died), and most youth of today have their challenges amplified as a result of the pandemic.

The UNAIDS (2010) HIV/AIDS global update underscores the disproportionate impact of the AIDS epidemic on women, especially in Sub-Saharan Africa. Slightly more than half of all people living with HIV are women and girls (UNAIDS, 2010). In sub-Saharan Africa, more women than men are living with HIV, and young women aged 15–24 years are as much as eight times more likely than men to be HIV positive.

The above sources show that young people are vulnerable to HIV, and there are other social factors that exacerbate the problem. Such include the social background, family background, cultural practices such as gender inequality and socioeconomic status.

2.3 FAMILY STRUCTURE

Modernity has posed challenges to the breaking down of family structures (Molokomme, 2006). During migrations, family patterns are broken as a result. Young people left behind (in the rural area) find themselves heading families. In such instances, it is easy for these young people to be highly vulnerable to HIV and Aids because of the family structure has been destroyed. The author directly associates the vulnerability to HIV infection with family structure. Other sources also associate types of family structure (though not in the researcher's definition thereof) with susceptibility to HIV infection. That is, orphaned children, or youth from families with no parents are vulnerable to HIV infection (UNAIDS, 2008; NACA 2002 & UNDP, 2001).

The impact of HIV/AIDS as stated earlier on has effects on the family structure that can be blamed for increased vulnerability of the youth today. According to UNESCO (2009), 95,000 children have lost at least one parent to the epidemic. Currently, the number of children orphaned due to HIV/AIDS has further increased from 14.6 million [12.4 million–17.1 million] in 2005 to 16.6 million [14.4 million–18.8

million] in 2009 worldwide. Of this group, almost 90% live in sub-Saharan Africa (UNAIDS/WHO, 2010).

In Botswana, a great number of children are also orphaned as a result of HIV/AIDS and many children and young people are left without parents. According to BAIS III (2008), the number of orphaned children was then estimated to be at 53 309 countrywide. This, according to the author can pose a significant risk to the young people who are raised by one or with none parenting guide.

HIV/AIDS claim young adults just as they start forming and bringing up families. As a result, orphan prevalence is rising steadily in many homes. This means that orphaned children face an increasingly uncertain future. Orphan hood is frequently accompanied by prejudice, increased poverty: factors that further jeopardise their chances their chances of getting HIV infection as they face their youth age (UNAIDS, 2010).

Cultural changes within the family structure (as a result of modernisation) have also affected the family structure (NACA, 2005). In the old, family was not only defined by the presence of one or two parents as it is nowadays. The extended family members were also present in the lives of the children, even when one of the parents was not available in the family. The extended family structure no longer helps in raising children as it used to be in the past. As a result, the youth find themselves having to head families if their biological parent dies or travels or work in a different town.

The BAIS II (2005) reports a high number of children who do not live with their biological parents. According to the survey, 48% of children of the sample population aged 0-18 in rural areas do not live with any of their biological parents, while 36.1 % of the children in urban areas had the same situation. About 63.9% of the children in the country were reported to be living with only one of the biological parents in urban areas as compared to 52% in rural areas. In the same reports most family units were female headed and have prevalence over 67%.

The Botswana AIDS Impact Survey II (2005) showed that half of all the households headed by women fell beneath the poverty line. The survey concluded that low economic factors increase the vulnerability to HIV infection of households or make families highly vulnerable to HIV infection. That is, by weakening the family ability to provide for basic needs, reducing access to health care and other life enhancing services or activities, increasing victimisation from discrimination, marginalisation and exploitation on different fronts and pushing or forcing the poor in relationships of dependency and submission, increase vulnerability to HIV. This study thus showed that HIV might thrive in environments where access to economic opportunities and basic services are compromised.

Food insecurity is widespread globally, and it reported to force people to use various types of coping behaviours, some which increase the likelihood of engaging in unprotected sex, particularly sexual risk taking among women, as they engage in transactional sex to procure food for themselves and their children (UNAIDS, 2010). This practise could be true to youth who are left to head families and have a need to support their younger siblings. Studies conducted around the world also prove food insecurity is associated with risky behaviours such as inconsistent condom use with non-primary partner, selling sex for money or resources and lacking sexual control and increased intergenerational sex (WHO, 2010; NACA, 2010 & UNAIDS, 2010).

In summary, the discussed findings points to young people from non-structured families being predisposed to having, for example, sexual relations in order to support their siblings or families. This may result in them being a high-risk group for HIV infection.

2.4 SEXUAL RISK FACTORS ASSOCIATED WITH HIV/AIDS INFECTION

Some literatures identify features of traditions and modern culture that heighten the vulnerability to HIV. These include the focus in sex and sex promotion by media, the use of sexual relationships for obtaining symbols of modern living which are quite expensive, high mobility of people which encourages chances of multiple sexual partners (NACA, 2006).

2.4.1 Societal Taboos, Norms and Values

Societies often compound young people's vulnerability by making it difficult for youth to learn about HIV and AIDS and reproductive health. In a Setswana culture, issues of sex and sexuality are seldom discussed with the youth, because this is termed a taboo (MoH, 2002). This tradition is believed to prevent young people from learning about sex so that they do not contract HIV. In actual fact, hiding information from the youth only make them even more vulnerable as they lack information to make informed decisions. On the other hand, youth shy away from getting information from the adults as they also feel 'uncultured' to discuss these issues.

2.4.2 Gender Inequality

The issue of gender inequality remains a contributing factor for young men and women's vulnerability to HIV. Male dominance in sexual decision making and violence against women and girls contribute directly to women's higher levels of HIV at earlier stages (NACA, 2006). This is largely to the traditions that undermine the decision making power of women. Young women are several times more likely than young men to be infected with HIV (NACA, 2004). Most African women find themselves confined to relationships that are controlled mostly by men, and cannot make their own independent decisions to stay HIV free.

Male dominance also makes young men particularly vulnerable to HIV infection. The young males are culturally expected to have more than one sexual partner to be manly or prove their manhood or see nothing wrong with the practice, and this on the other hand is risky as it increases their vulnerability to HIV. Male supremacy and dominance to take initiation in sexual practices and do not allow women (married or unmarried) to question men about any promiscuity, for example a common saying: '*Monna ga a botswe gore o tswa kae?*' This statement when directly translated it means that 'a man is not supposed to be asked about where he is coming from or asked about promiscuity' (MoH, 2002).

2.4.3 Intergenerational Sexual Relations According to the NACA survey (2005), sexual relations between older men and younger women are believed to explain the higher rates of infection seen in young women. Along the same lines, UNAIDS

(2010) also states that age disparate sex is one of the key drivers of the epidemic in many instances. Intergenerational sexual relations even involve younger men and older women. Many of these relationships are predatory reports the survey. The older, better-resourced men and women prey on sexually naïve or economically dependent girls and boys (NACA, 2005). According to the survey, intergenerational sex may involve family members as well as may account for a significant portion of first time sexual intercourse among young girls (this is more common in orphaned children). In other instances, young girls are given in marriages to partners who are more than ten years older their age for financial gain.

2.4.4 Socio-Economic Factors

Socio-economic factors that may have led to the spread of the rapid spread of HIV/AIDS are diverse in Botswana. These may include having multiple sexual partners with sugar daddies, or sugar mommies, and coercive sex with young virgins in the belief that one will be healed. Poor socio-economic status also poses a risk to young people (UNAIDS 2010). The youth are generally without any financial base because they may be unemployed, students or just starting to work. This status is even compounded in the young people that come from families that are poor or without parents according to the UNAIDS report. They could be easily forced in to sex sale in order to support themselves or their family members.

In a recent study conducted in Botswana poverty has proven to be directly associated with loss of power and control during sexual relations, increased odd of selling sex for money and resources, engaging in unprotected sex and lack of sexual control during intergenerational sex (MoH, 2010).

2.4.5 Stigma and Discrimination

Stigma and secrecy surrounding HIV- driven by mistrust, fear and cultural attitudes have had a negative effect and has also fuelled the transmission of the virus (MoH, 2002). The fear to experience rejection and discrimination continue to inhibit prevention, testing and treatment. This fear keeps people from confirming their status, from accessing information and services about opportunistic infection and sexually transmitted diseases. According to NACA (2006), people would rather ignore the fact

they might be infected with HIV than face the consequences of stigma and rejection. Fear of social stigma also keep many of the epidemic in many places hidden and unacknowledged in many parts of the world (UNAIDS/WHO 2010). This may mean that the transmission of the virus spread because it is not openly discussed.

2.4.6 Religious Practices and Beliefs

There are religious practices in Botswana that facilitate HIV transmission. Such include cleansing rituals that involve having sex by older men with virgin girls in belief that they are cleansing their blood (MoH, 2002). There are other traditional beliefs that actually engage in sexual relations between the practioners and the clients (MoH, 2002). Some religious groups discourage the use of any contraceptive to prevent pregnancy. This, according them is against the will of God to prevent pregnancy including the use of condoms. Some believe that men are instructed by God to sleep with younger girls (MoH, 2002).

2.4.7 High Mobility

Botswana people are highly mobile and this trend is responsible for most HIV transmission as people form new sexual relationships in the areas they travel (MoH, 2002). Another study found that more affluent women are at greater risk of contracting HIV, as they are more mobile, more likely to live in an urban area, and more able to afford a lifestyle that includes having a higher number of sexual partners (UNAIDS, 2010). Even to the employed people, paid sex appears to be commonplace among mobile populations, including migrant workers, transport workers, and military personnel (UNAIDS/WHO, 2010).

2.4.8 Alcohol and Drug Abuse

Alcohol abuse is recognised as a major problem in Botswana. The use of this inhibitor is responsible for acquiring and transmitting HIV especially among the young people (NACA, 2004). Research in Botswana has also confirmed that alcohol can cloud a person's judgement and make him or her something she would normally not do (Gobotswanang, 2003 as cited in NACA, 2004). People under the influence of alcohol are more likely to have unintended sex and unprotected sex than when there are sober.

Conversely, traditional roles and societal values related to masculinity might encourage boys and men to adopt risky behaviours, including excessive alcohol use and concurrent sexual relationships, thereby increasing their risk of acquiring and transmitting HIV (UNAIDS 2010). Women and girls also may be in the habit of using excessive alcohol use, as a result may have multiple concurrent partners or have sex with men under the influence of alcohol for money purposes.

2.4.9 Adolescent Stage

Some literature point out to the adolescent stage of development as the reason for the vulnerability of young people toward HIV infection. The social, emotional and psychological development of young people is (generally) incompetent, and they tend to experiment with risky behaviours often with little awareness of the danger (Ball, 1996 & USAID, 2009). According to the USAID survey, risky sexual behaviour is often part of a larger pattern of adolescent behaviour, including alcohol and drug abuse, delinquency and challenging authority.

Adolescents are often not able to comprehend fully the extent of their exposure to risk (USAID, 2009). Even when they appreciate the risks associated with HIV/AIDS in general, many young people do not believe that there are invulnerable themselves (WHO, 2008 & Ball, 1996).

Moreover, young people are socially inexperienced, and therefore dependent on other peers to make decisions. Peer pressure makes these decision making, that is skewed mostly towards risky behaviours can make one even more vulnerable when there are orphans situations. Peer pressure influences them, often in ways that can increase the risk of being infected with the virus (MoH, 2002).

On the contrary, some researchers (Marks, Ball, Cerrullo, & Cook, 2001 & Garbarino, 1992) believe that young people should not be viewed as simply vulnerable. This, according to them can cloud the understanding of youth situation and limit them (the youth) the ability to think for themselves (Marks et al, 2001). The theory that 'sees young people as highly vulnerable' for whatever reason can also stand as a challenge in inhibiting the youth to engage in non-risky behaviours and non-risky sexual

behaviours, they argue. In this theory, researchers believe that with education young people are also capable of making decisions and can even engage in non-risky behaviours amidst all odds.

Ball (2006) also conceptualises how young people in Botswana formulate their ideas concerning sexual risk. This formulation is set against an alarming rate of HIV infection among the youth, high rates of sexually transmitted diseases, and teen pregnancy. In considering how young people formulate their ideas and make choices about their health vis-à-vis sexual relationship, she argues that these decisions are inextricably linked to social structures and cultural norms.

Ball (1996) states that until we understand how young people define sexual risk within the overall context of their lives it is inappropriate to focus solely on issues of individual sexual risk, as defined by epidemiology, biomedicine or social sciences. According to the author, we must broaden our view and understanding of risk and sexual risk. We are also to consider more than just the individual risk but consider interpersonal context, the socio cultural and the structural for they all influence the health decisions of the youth.

2.5 SUMMARY

Although the risk factors associated with HIV infection are diverse, there are practises and behavioural patterns that are common among young people. As literature sources have eluded, the use of alcohol and drugs, in many instances, can lead to unsafe sex. Multiple concurrent sexual partners is also a common problem, some of these are between youth and people more than ten years their age. In other instances, young people are also vulnerable because they lack a strong economic base, and consequently engage in sex sale to acquire basic needs of life.

From the above, the following sexual risk factors have been identified:

- Unsafe Sex
- Multiple Sexual Partners

- Intergenerational Sex
- Sex for Money

In the next chapter, this study's design and methodology will be discussed where more information will be given on the questionnaire that was developed around the abovementioned sexual risk factors associated with HIV infection as well as how the research problem (i.e. whether family structure predisposes youths to these factors) was tested.

CHAPTER 3: STUDY DESIGN AND METHODOLOGY

3.1 RESEARCH DESIGN

Descriptive Approach, according to Christensen, (2006) gives input regarding the effectiveness of the proposed solution (decreasing the transmission rate of HIV among youth) to the solution as well as hypothesis about how a more effective solution can be reached. This approach tends to identify the casual relationships, variables that exist in given situations, and at times to describe the relationship that exist between variables. The descriptive research approach also provides a description or a picture of a particular situation, and tries to describe the relationship that exists between variables (Christensen, 2006).

Questionnaires were distributed among 130 participants from University of Botswana students, high school students from Gaborone Secondary school and some participants were interviewed from Old Naledi Location in Gaborone.

3.2 STUDY POPULATION

Out of the 130 participants, 128 participants completed questionnaires. Two questionnaires were spoiled and incomplete and therefore were rejected. Lobbying was done in the before mentioned areas to target the population sample of young people aged 14-24. The sample size target was to have 30 participants from each group as described in Table 3.3.1.

3.3 SAMPLING

In this study, the researcher used Haphazard Sampling. Christensen (2006) defines it as a non-probability sampling technique whereby the sample of participants selected is based on convenience and availability. The questionnaire was introduced to students in their hall of residence, in the library and in one of the busy streets of Old Naledi location as well as in Gaborone Senior Secondary School. Those who were

willing to complete the questionnaire were allowed to complete the questionnaire. Participants were identified in a period of 2 weeks.

3.3.1 Sample Size

In total, one hundred and twenty participants from the different age groups were targeted in the study: 30 participants in the age group 14-18 from non-structured families; 30 participants in the age group 14-18 from well-structured families; 30 participants in the age group 19-24 from non-structured families; and 30 participants in the age group 19-24 from well-structured families.

AGE GROUP	FAMILY STRUCTURE	#
14-18	Non-structured family	30
14-18	Well-structured family	30
19-24	Non-structured Family	30
19-24	Well-structured	30

TABLE 3.3.1 showing how the sample population will be structured

3.4 DATA COLLECTION

Participants were approached one by one or in groups and given the questionnaire to look at. The questionnaire was either completed by the researcher or by the participant depending on the preference of the participant. At the beginning of the questionnaire, introduction of the study was made to the participant and verbal consent sought. Those who agreed to complete the questionnaire were allowed to complete the questionnaire and those who refused to take were not given the questionnaire to complete. Those who returned the questionnaire not completed at all were also taken to be not interested in taking part in the study, and their decision was respected.

3.5 QUESTIONNAIRE CONSTRUCTION

In constructing a questionnaire, it is necessary to construct a questionnaire that will provide an answer to the research question (Christensen, 2006). There are a number of factors to be considered when constructing a questionnaire. These, according to Christensen include the types of questions to be used, the wording of the questions, how the questions have been arranged, and the length of the questions as well as response biases such as social desirability bias (responding to questions to look good rather than as one truly feels and believes) and response set (the tendency to respond in a specific way).

Data was solicited from the participants through administering a structured questionnaire. The questionnaire had demographic information (age group, educational background, and employment status), family structure and risk profile questions. The demographic part of the questionnaire categorised participants as follows: 14-18 age group from non-structured families; 19-24 age group from non-structured families; 14-18 age groups from well-structured families; and 19-24 age groups from well-structured families.

The risk profile questions solicited whether participants were involved in risky behaviours or not. See appendix I for the questionnaire used. The following table summarises the number of participants who completed the questionnaire.

AGE GROUP	FAMILY STRUCTURE	#
14-18	Non-structured family	30
14-18	Well-structured family	30
19-24	Non-structured Family	30
19-24	Well-structured	38
	Incomplete	3
	Total	128

Table 3.4.1 showing the actual sample size that completed the questionnaire

In this study, structured interview close ended type of questions was used. Participants were required either to tick the most appropriate or correct in statement that were provided. This method according to Bless et al. (2000) is an established set of questions with fixed wording and sequence of presentation as well as more or less indication on how to answer each question. The questionnaire was presented to each participant in exactly the same way to minimise the role and influence of the interviewer hence a more comparison of the results (Bless et al. 2000). Participants completed the questionnaire anonymously and were assured that the questionnaire is voluntary and confidential. It was emphasized that no part of their personal identification will be used (not their name or any other information that could be used to identify them) in the study.

The questionnaire comprised of the following questions:

- Question 1 of the questionnaire was about whether someone is sexually active or not. (There is an instruction for those who are not sexually active to stop continuing with the questionnaire or stop completing the rest of the questionnaire.)
 - Those who are sexually active were considered to be vulnerable.
 - Those who answered not to be sexually active were considered as not vulnerable.
- The second question of the Questionnaire was to ascertain that someone had Sex in the past 12 months.
 - Those who answered yes to this question are deemed vulnerable
 - Those who answered no, and yet sexually active, were deemed to be either were sexually active in the past, or had a behavioural change.
- Question 3 of the questionnaire asked about if participant have had sex with someone who they know had given money in exchange for sex.
 - Those who answered ‘yes’ to question 3 are termed vulnerable.
 - Those who answered ‘no’ to question 3 are not vulnerable.
 - Those who answered not sure not also vulnerable

- In the fourth question, a history of non-regular sexual partner is questioned and the same information is being solicited from question 5-whether someone had sex with more than one partner in the past 12 months.
 - Those who answered 'yes' to the two questions are termed vulnerable
 - Those who answered 'no' are not vulnerable
 - Those who answered 'not sure' are also termed vulnerable
- Question 6 asks about unprotected sex with someone whose HIV status is not known.
 - Those who answered in the affirmative or 'not sure' are taken to be highly vulnerable
 - Those who answered no are not vulnerable.
- Question 7 in the questionnaire wants to find out how many sexually active participants have gone for HIV testing in the past 12 months.
 - Those who answered in the affirmative or 'not sure' are taken to be highly vulnerable
 - Those who answered no are not vulnerable.
- Question 8 seeks to find out if participants have been treated for a sexually transmitted disease.
 - Those who answered in the affirmative for having been treated also seem to have history of unprotected sex and hence more vulnerable
 - Those who answered 'no' are termed not vulnerable.
- In question 9, the questionnaire asks if participants have had sex with someone older than 10 years.
 - Those who answered yes or not sure are also termed vulnerable.
 - Those who answered no are taken not to be vulnerable.
- In question 10, participants are asked if they occasionally have sex for money.
 - Those who answered yes or not sure are also termed vulnerable.
 - Those who answered no are taken not to be vulnerable.
- In question 11, participants are asked whether they have a history of unprotected sex under the influence of alcohol.
 - Those who answered yes or not sure are also termed vulnerable.
 - Those who answered no are taken not to be vulnerable.

3.6 DATA ENTRY, CLEANING AND CODING

After all data has been collected from the sample group, each questionnaire was given a unique participant identity number. Data from questionnaires was keyed in an excel format to form a database. Entry made in the database was double checked for consistency and was corrected to ensure high quality data.

Data was then coded to make it friendly with analysis purposes. For demographic questions, age groups were coded as follows (14-18=1 and 19-24=2), gender (female 1, and male 2), educational background (primary=1, secondary =2 and tertiary=3 and employment status was coded as (employed and self-employed =1, unemployed=2 and student 3). The risk profile questions were answered as follows: yes, no or not sure and were coded 1, 2, and 3 respectively. Some questions were not answered in some questionnaires and therefore coded 99.

3.7 STATISTICAL ANALYSES AND PACKAGES

Statistical Package for the Social Sciences (SPSS) was used in analysing the data. SPSS is among the most widely used programs for statistical analysis in social science.

3.8 ANALYSIS OF DATA

The primary objective of the analysis was to find out whether there is a significant difference between well-structured and non-structured families in terms of predisposing youths to certain sexual risk factors associated with HIV infection (encapsulated in the attached questionnaire).

Secondary analysis of data means other findings of the study that are not necessarily the main objective of the study. Other information that was solicited from this study include: Behavioural patterns such as age group and gender, that is more sexually active, trends and relationships between variables such the level of education in relationship to HIV testing, gender in relation to HIV, the age group that is more

highly sexually active, how the level of education affect one to be involved in unprotected sex under the influence of alcohol and how unemployment as a factor affect ones sexual risk profile is extracted from the study.

The general risk profile of the entire population sample was assessed as well. This analysis helps the researcher to know a percentage of sample population that is involved in inter-generational sexual relationships, a percentage of the sample population that is involved in unprotected sex and the percentage of the sample population that is involved in sex sale.

3.9 ETHICAL CONSIDERATIONS

Throughout the process of data collection, the problem of persuading participants to co-operate with the researcher is ever present. Lack of cooperation leads to non-response, incomplete filled questionnaires, and leading to unreliable results (Bless, 2000).

While lack of cooperation can be disastrous to research studies, participants have the right to refuse to take part (Bless et.al, 2000). During the data collection process, the researcher ensured that participant's choice not to participate in the study was respected. The following fundamental ethical principles were observed in order to protect the participants:

- *Informed consent* –this involved informing the participants about all aspects of the study, from the purpose of the study, the procedures, any risks and benefits of the study if there was any. The participant has a fundamental right to take part or not in the study. (Christensen, 2006). Participants were asked to give verbal consent.
- *Respect for persons and their autonomy*- an autonomous person is someone who makes informed decision and follow through on those decisions (Christensen, 2006). This principle was adhered to by giving all information to the participants that may influence their willingness to take part in the study. Study participants were informed that taking part in the study was voluntary, and there was no direct benefit for taking part in the study.

- *Principle of Anonymity*-This, according to Christensen, (2006) is simply keeping the identity of the research participant unknown. There were no names or identifiers of participants used on the questionnaires. Participants were asked not to write their names on the questionnaire.
- *Principle of confidentiality*-According to Christensen (2006) confidentiality means not to reveal any information about the research participant to anyone outside the study team. In this study, the responses, perceptions, and attitudes of the participants were not revealed to anyone outside the study team. Participants were assured that there will be no form of any publication that will reveal participants by their names or any identifiers.

CHAPTER 4: RESULTS

4.1 INTRODUCTION

This chapter gives a summary of the results in both descriptive and analytic forms. Descriptive statistics and associations using univariate analysis and measures for association were used. The first section comprises of demographic characteristics of participants. In the second section, each question is discussed separately in order to determine whether there was a difference between well-structured and non-structured families in terms of predisposing youths to a certain sexual risk factor associated with HIV infection addressed in that specific question.

The second part of the results seeks to determine cross tabulations between variables (Section 4.13). Behavioural patterns, trends and relationship between variables were established. Such relationships [discussed in this section] include relationships between demographic characteristics (age, gender, educational background and employment status) and other risk factors such as being sexually active, HIV testing, a history of a sexually transmitted disease and having a partner who is ten years older than ones age.

4.1.1 Demographic characteristics

Those who admitted to be sexually active are the ones who proceeded in answering other questions, and those who denied being sexually active stopped with just this first question.

	Variable	Frequency	Percent
Age	14-18	61	48
	19-24	67	52
	Total	128	100
Gender	female	67	52
	Male	61	48
	Total		
Education	primary	3	2
	secondary	77	60
	tertiary	48	38
	Total	128	100
Employment	employed	15	12
	unemployed	37	29
	student	76	59
	Total	128	100
Family structure	Non-structured	58	45
	well-structured	70	55
	Total	128	100

Table 4.1.1: Demographic characteristics of the participants

4.1.2 Participants by sexual activity

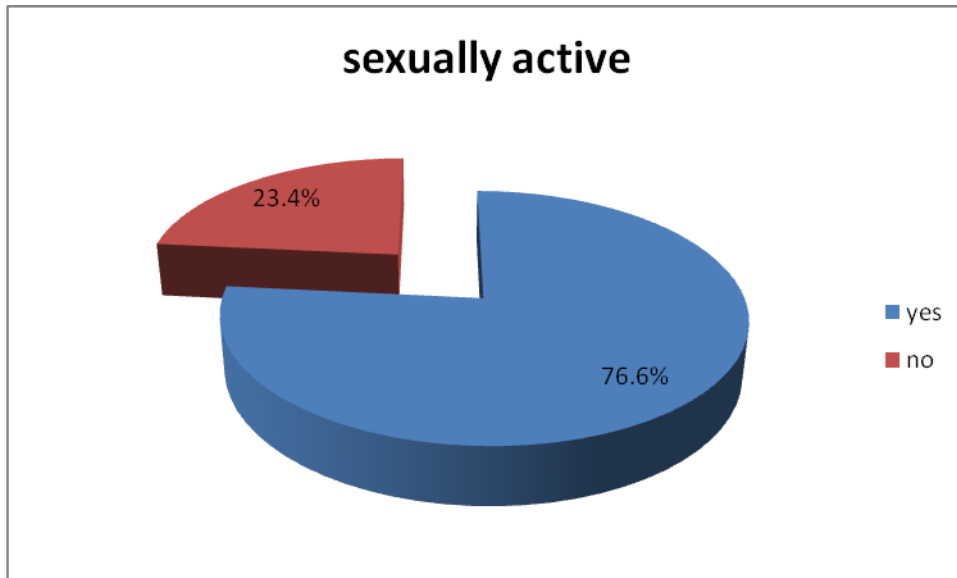


Figure 4.1.2 Pie chart showing the number of participants who indicated that they are sexually active

4.1.3 Distribution by age

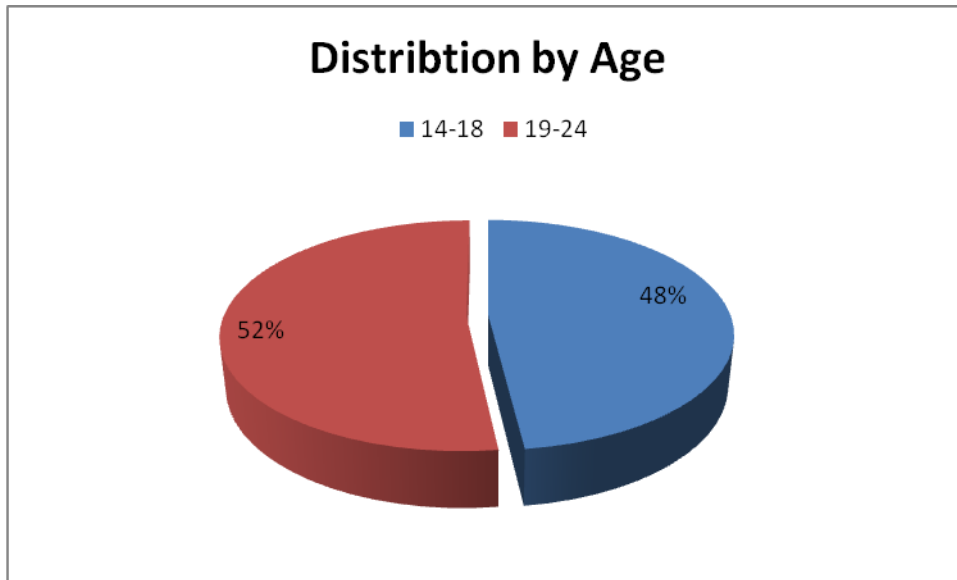
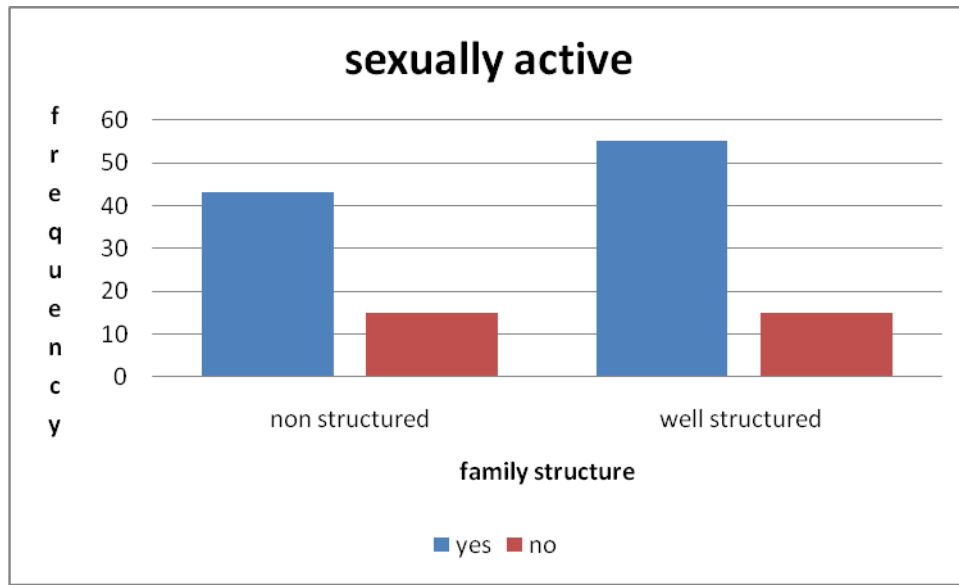


Figure 4.1.3 showing distribution by Age of population Sample

4.2 Question 1: RESULTS SHOWING BEING SEXUALLY ACTIVE AGAINST FAMILY STRUCTURE



Graph 4.2 showing the number of young people who are sexually active by family structure

Question 1 was answered as follows:

Non-structured Family

- Sexually active : 74.1%
- Not sexually active : 25.9%

Well-structured Family

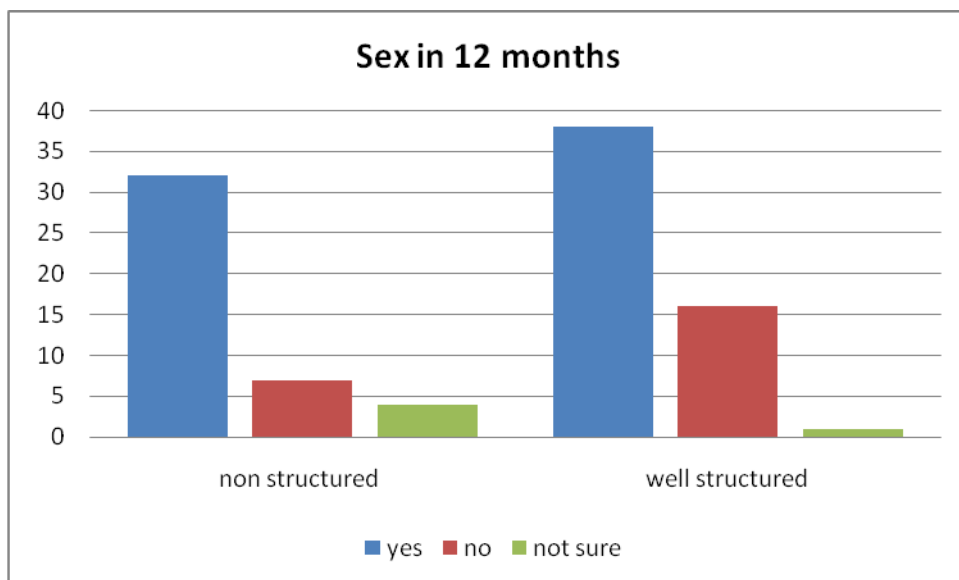
- Sexually active : 78.6%
- Not sexually active : 21.4%

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.347(b)	1	.556		
Continuity Correction(a)	.144	1	.704		
Likelihood Ratio	.346	1	.556		
Fisher's Exact Test				.676	.351
Linear-by-Linear Association	.345	1	.557		
N of Valid Cases	128				

Table 4.2.1 showing Chi-Square Tests for Family structure against sexually active

A Chi-square test was performed to determine whether those who was sexually active was distributed differently across family structure. There was no statistically significant association between family structure and being sexually active ($\chi^2 (1) = 0,35; p = 0,56$).

4.3 Question 2: RESULTS SHOWING HAVING HAD SEX IN THE LAST 12 MONTHS AGAINST FAMILY STRUCTURE



Graph 4.3 showing the number of young people who admit to have had sex in the past 12 months by family structure

Question 2 was answered as follows:

Non-structured Family

- Yes : 74.4%
- No : 16.3%
- Not sure : 9.3%

Well-structured Family

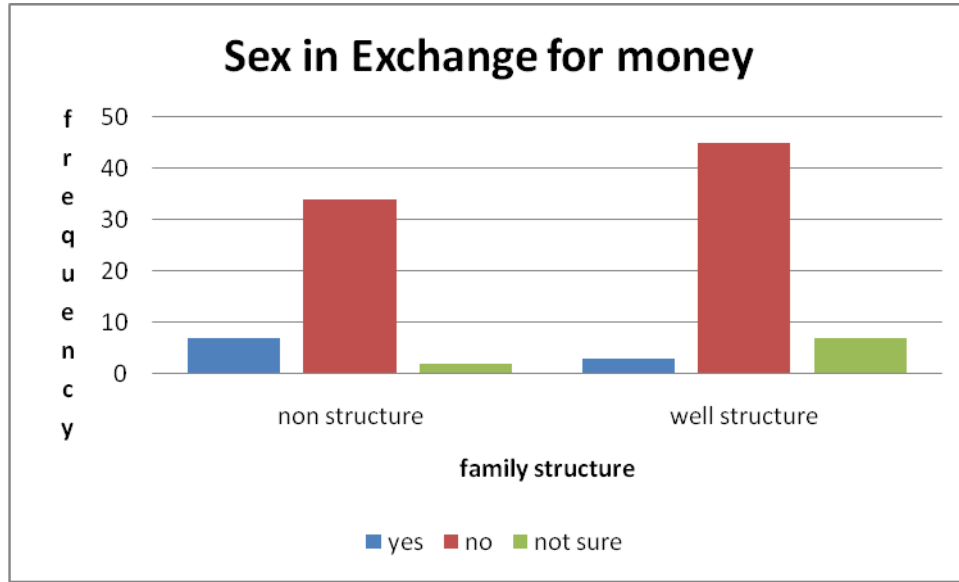
- Yes : 69.1%
- No : 29.1%
- Not sure: : 1.8%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.433(a)	2	.109
Likelihood Ratio	4.587	2	.101
Linear-by-Linear Association	.034	1	.853
N of Valid Cases	98		

Table 4.3.1 showing Chi-Square Tests for Family structure against Sex in the last 12 months

A Chi-square test was performed to determine whether those who had sex in the last 12 months was distributed differently across family structure. There was no statistically significant association between family structure and having had sex in the last 12 months ($\chi^2 (2) = 4,43; p = 0,10$).

4.4 Question 3: RESULTS SHOWING HAVING HAD SEX WITH SOMEONE IN EXCHANGE FOR MONEY AGAINST FAMILY STRUCTURE



Graph 4.4 showing the number of participants who had sex in exchange for money

Question 3 was answered as follows:

Non-structured Family

- Yes : 16.2 %
- No : 79.1%
- Not sure : 4.7%

Well-structured Family

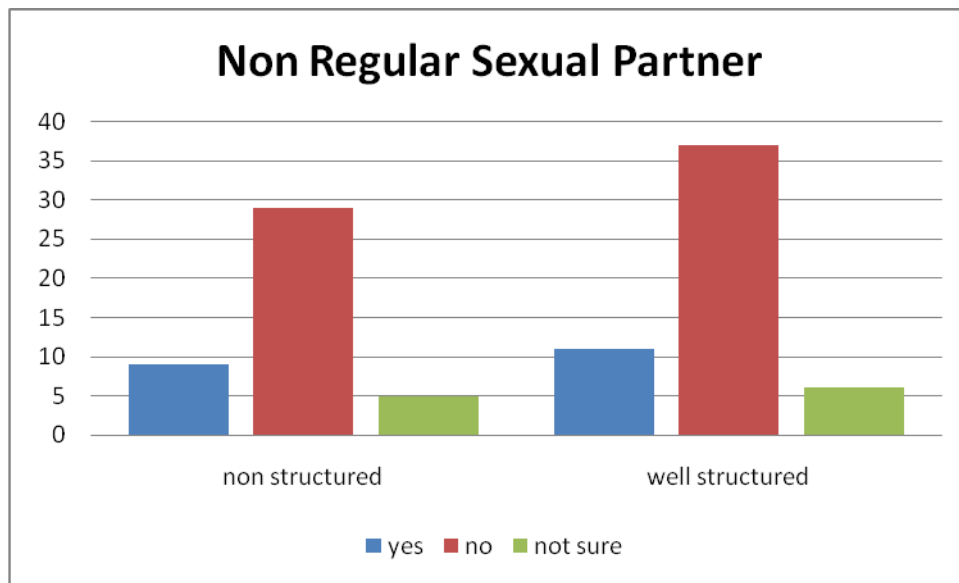
- Yes : 5.45% :
- No : 81.8%
- Not sure: : 12.7%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.508(a)	2	.105
Likelihood Ratio	4.651	2	.098
Linear-by-Linear Association	4.404	1	.036
N of Valid Cases	98		

Table 4.4.1 showing Chi-Square Tests for Family structure against Money in Exchange for Sex

A Chi-square test was performed to determine whether those who accepted money in exchange for sex was distributed differently across family structure. There was no statistically significant association between family structure and accepting money in exchange for sex ($\chi^2 (2) = 4.50; p = 0,10$).

4.5 QUESTION 4: RESULTS SHOWING HAVING HAD SEX WITH NON-REGULAR SEXUAL PARTNER IN THE PAST 12 MONTHS AGAINST FAMILY STRUCTURE



Graph 4.5 showing the number of participants who had sex with non-regular Sexual partner

Question 4 was answered as follows:

Non-structured Family

- Yes : 20.9 %
- No : 67.4%
- Not sure : 11.6%

Well-structured Family

- Yes : 20.0 % :
- No : 67.3 %
- Not sure: : 10.9 %
- No answer : 1.8%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.013(a)	2	.993
Likelihood Ratio	.013	2	.993
Linear-by-Linear Association	.000	1	.997
N of Valid Cases	97		

Table 4.5.1 Showing Chi Square Test between Family structure and Non Regular Sexual Partner

A Chi-square test was performed to determine whether those who had a non-regular sex partner was distributed differently across family structure. There was no statistically significant association between family structure and having a non-regular sex partner ($\chi^2 (2) = 0,01; p = 0,99$).

4.6 QUESTION 5: RESULTS SHOWING HAVING HAD SEX WITH MORE THAN ONE SEXUAL PARTNER IN THE PAST 12 MONTHS AGAINST FAMILY STRUCTURE

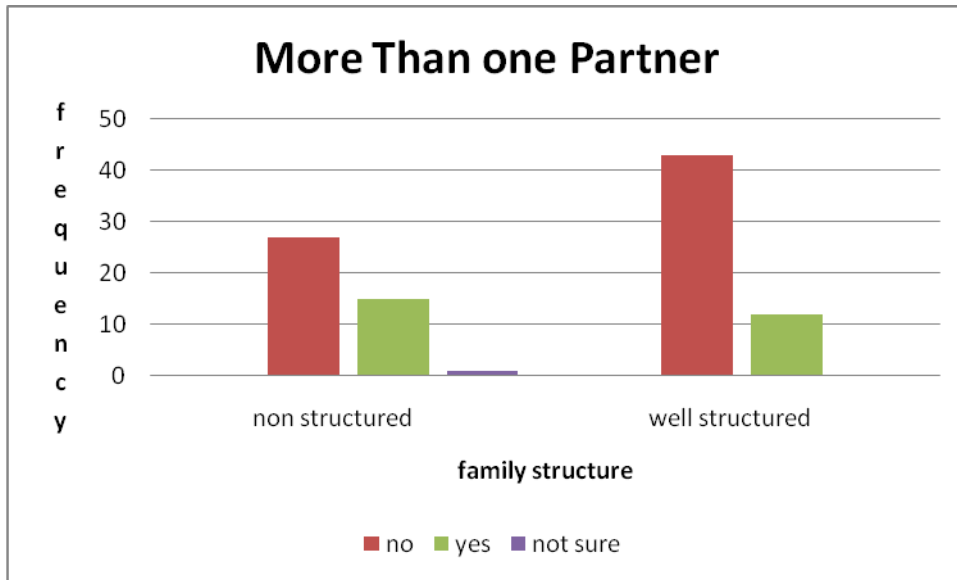


Figure 4.6 The graph showing the number of participants who had sex with more than sexual partners against family structure

Question 5 was answered as follows:

Non-structured Family

- Yes : 34.9 %
- No : 62.8%
- Not sure : 2.3%

Well-structured Family

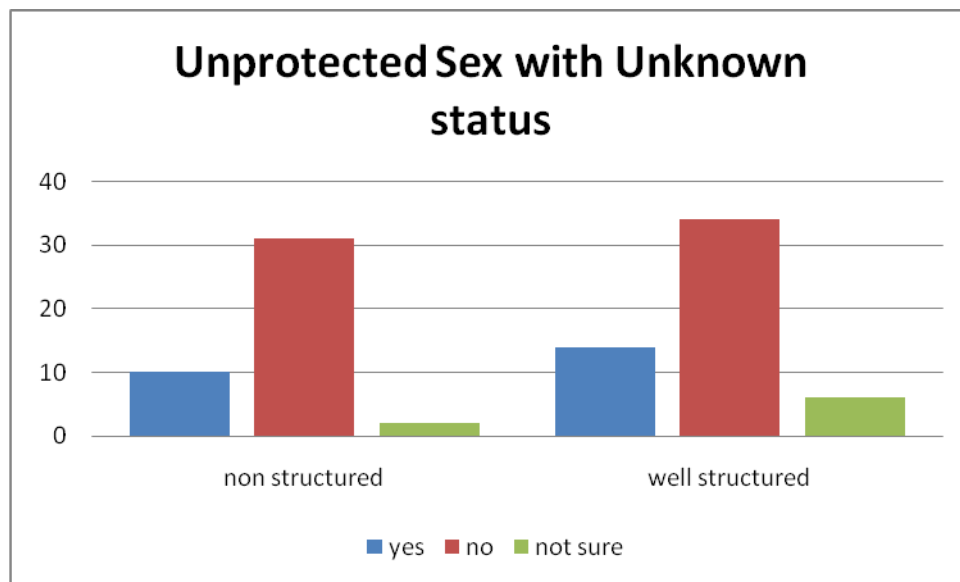
- Yes : 21.8% :
- No : 78.2 %
- Not sure : 0%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.575(a)	2	.167
Likelihood Ratio	3.937	2	.140
Linear-by-Linear Association	1.280	1	.258
N of Valid Cases	98		

Table 4.6.1 Showing Chi Square Test between Family structure and More than one sexual partner

A Chi-square test was performed to determine whether those who had more than one sexual partner in the last 12 months was distributed differently across family structure. There was no statistically significant association between family structure and having more than sexual partner in the last 12 months ($\chi^2 (1) = 3,58; p = 0,17$).

4.7 QUESTION 6: RESULTS SHOWING HAVING HAD UNPROTECTED SEX WITH SOMEONE WHOSE HIV STATUS IS NOT KNOWN AGAINST FAMILY STRUCTURE



Graph 4.7 Showing number of participants who had unprotected sex with someone with unknown HIV status

Question 6 was answered as follows.

Non-structured Family

- Yes : 23.3 %
- No : 72.1%
- Not sure : 4.7%

Well-structured Family

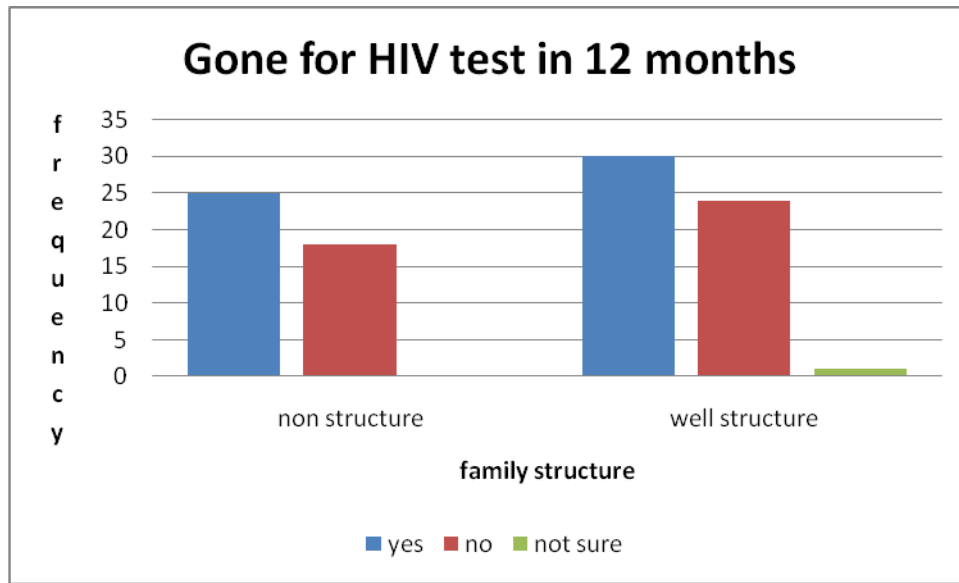
- Yes : 25.5 %
- No : 61.8 %
- Not sure : 10.9%
- No answer : 1.8%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.371(a)	3	.499
Likelihood Ratio	2.815	3	.421
Linear-by-Linear Association	.813	1	.367
N of Valid Cases	98		

Table 4.7.1 Showing Chi Square Test between Family structure and unprotected sex with someone with unknown HIV

A Chi-square test was performed to determine whether those who had unprotected sex with someone with an unknown HIV-status was distributed differently across family structure. There was no statistically significant association between family structure and having unprotected sex with someone with an unknown HIV-status (χ^2 (3) = 2,37; $p = 0,49$).

4.8 QUESTION 7: RESULTS SHOWING HAVING GONE FOR AN HIV TEST IN THE PAST 12 MONTHS AGAINST FAMILY STRUCTURE



Graph 4.8 showing the numebr of participants that have gone for an HIV test in the past 12 months

Question 7 was answered as follows:

Non-structured Family

- Yes : 58.1 %
- No : 41.9 %
- Not sure : 0 %

Well-structured Family

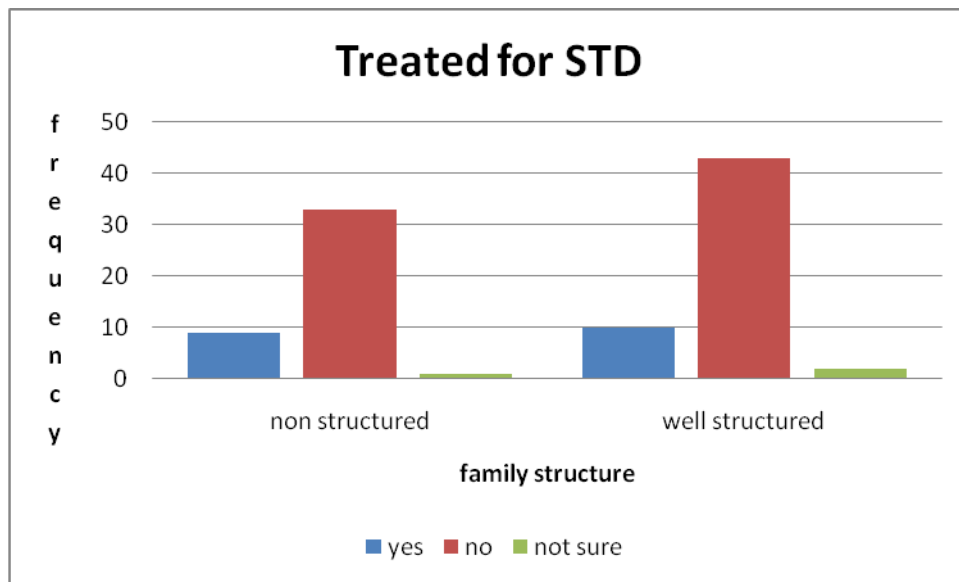
- Yes : 54.5% :
- No : 43.6 %
- Not sure : 1.8%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.868(a)	2	.648
Likelihood Ratio	1.242	2	.537
Linear-by-Linear Association	.279	1	.597
N of Valid Cases	100		

Table 4.8.1 Showing Chi Square Test between Family structure and having gone for an HIV test in the past 12 months

A Chi-square test was performed to determine whether those who had gone for an HIV test in the last 12 months was distributed differently across family structure. There was no statistically significant association between family structure and having gone for an HIV test in the last 12 months ($\chi^2 (2) = 0,87; p = 0,65$).

4.9 QUESTION 8: RESULTS SHOWING HAVING HAD A SEXUALLY TRANSMITTED DISEASE IN THE PAST AGAINST FAMILY STRUCTURE



Graph 4.9 Showing the number of participants who had STD in the past against family structure

Question 8 was answered as follows:

Non-structured Family

- Yes : 20.9 %
- No : 76.7 %
- Not sure : 2.3%

Well-structured Family

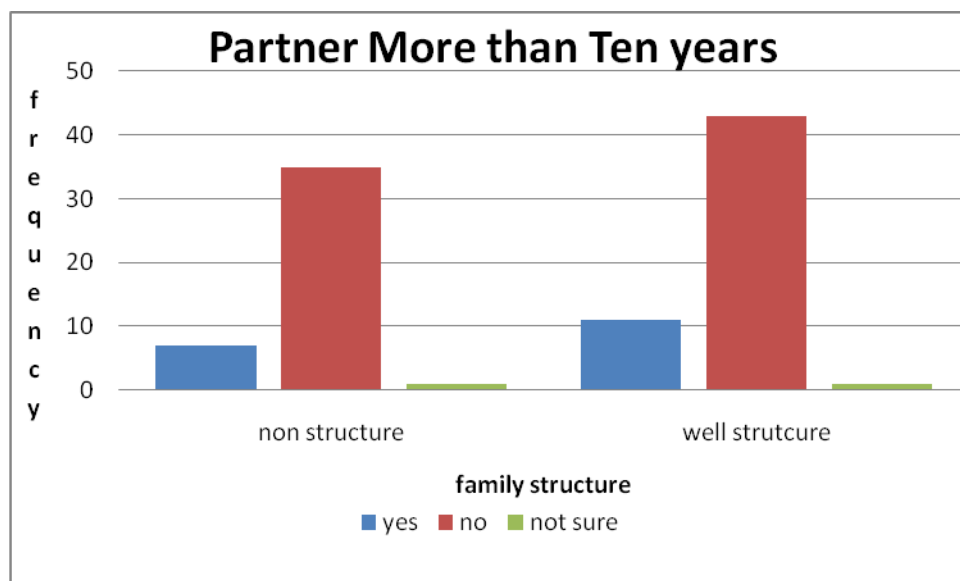
- Yes : 18.2%
- No : 78.2%
- Not sure : 3.64%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.236(a)	2	.889
Likelihood Ratio	.239	2	.887
Linear-by-Linear Association	.199	1	.656
N of Valid Cases	98		

Table 4.9.1 Showing Chi Square Test between Family structure and having been treated for a Sexually transmitted Disease

A Chi-square test was performed to determine whether those who had been treated for an STD was distributed differently across family structure. There was no statistically significant association between family structure and STD treatment ($\chi^2 (2) = 0,23; p = 0,89$).

4.10 QUESTION 9: RESULTS SHOWING HAVING HAD A PARTNER WHO IS TEN YEARS OLDER AGAINST FAMILY STRUCTURE



Graph 4.10 Showing having had a partner who is ten years older against family structure

Question 9 was answered as follows:

Non-structured Family

- Yes : 16.3 %
- No : 81.1 %
- Not sure : 2.3 %

Well Structured Family

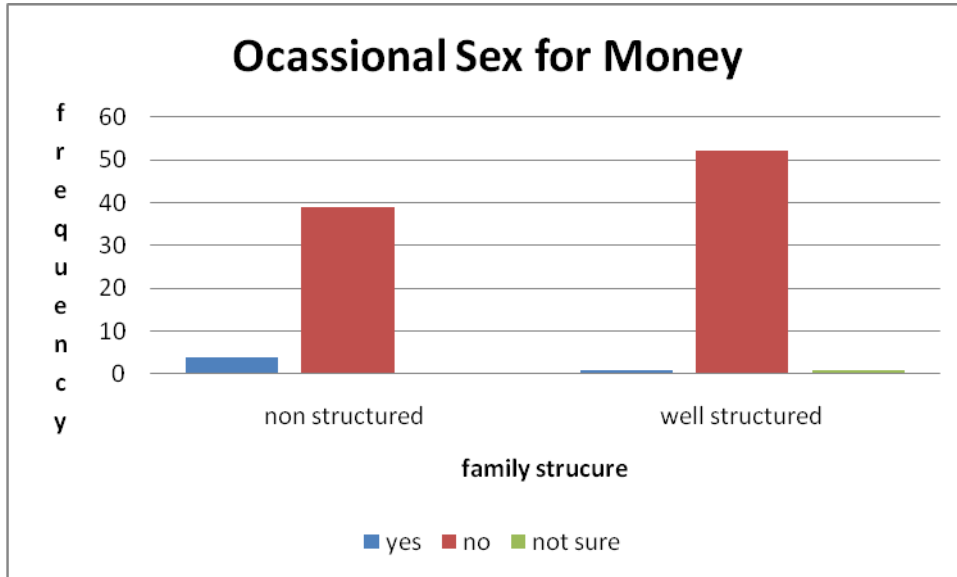
	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.506(a)	3	.681
Likelihood Ratio	1.880	3	.598
Linear-by-Linear Association	1.295	1	.255
N of Valid Cases	99		

Table 4.10.1 Showing Chi Square Test between Family structure a partner who is ten years older against family structure

- Yes : 20.0 % :
- No : 78.2 %
- Not sure : 1.8 %

A Chi-square test was performed to determine whether those who had a partner 10 years older was distributed differently across family structure. There was no statistically significant association between family structure and having a partner who is 10 years older ($\chi^2 (3) = 1,50; p = 0,68$).

4.11 QUESTION 10: RESULTS SHOWING HAVING HAD OCASSIONAL SEX FOR MONEY AGAINST FAMILY STRUCTURE



Graph 4.11 Showing participants who have occasional sex for money

Question 10 was answered as follows:

Non-structured Family

- Yes : 9.3 %
- No : 90.7 %
- Not sure : 0 %

Well-structured Family

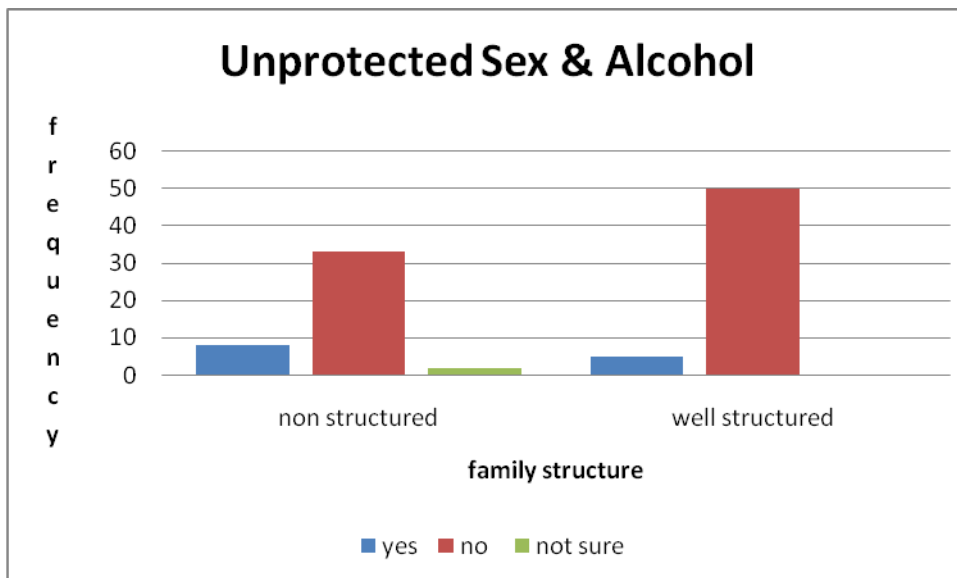
- Yes : 1.8 %
- No : 94.5 %
- Not sure : 1.8 %
- No answer : 1.8 %

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.252(a)	3	.236
Likelihood Ratio	5.090	3	.165
Linear-by-Linear Association	.865	1	.352
N of Valid Cases	98		

Table 4.11.1 Showing Chi Square Test between Family structure and occasional sex for money

A Chi-square test was performed to determine whether those who had occasional sex for money was distributed differently across family structure. There was no statistically significant association between family structure and occasional sex for money ($\chi^2(3) = 4.25; p = 0,24$).

4.12 QUESTION 11: RESULTS SHOWING HAVING HAD UNPROTECETD SEX UNDER THE INFLUENCE OF ALCOHOL AGAINST FAMILY STRUCTURE



Graph 4.12 Showing having unprotected sex under the influence of alcohol

Question 11 was answered as follows:

Non-structured Family

- Yes : 18.6 %
- No : 76.7 %
- Not sure : 4.7 %

Well-structured Family

- Yes : 9.1 % :
- No : 90.9 %
- Not sure : 0%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.776(a)	2	.092
Likelihood Ratio	5.505	2	.064
Linear-by-Linear Association	.402	1	.526
N of Valid Cases	98		

Table 4.11.1 Showing Chi Square Test between Family structure and having had unprotected sex under the influence alcohol

A Chi-square test was performed to determine whether those who had unprotected sex under the influence of alcohol was distributed differently across family structure. There was no statistically significant association between family structure and those who had unprotected sex under the influence of alcohol ($\chi^2 (2) = 4,77; p = 0,92$).

4.13 CROSS TABULATION: SECONDARY ANALYSIS OF DATA

The following tables describe the cross tabulation between risk factors of interest such as the age group and gender group is more sexually active, how HIV testing is associated with age, gender, employment and history of being treated for a sexually transmitted disease. Other variables tested were non-regular sexual partners with HIV

test, unprotected sex with having a partner more than ten years, and multiple sexual partners. The discussion of these tables will follow under each table.

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.699(a)	2	.000
Likelihood Ratio	18.546	2	.000
Linear-by-Linear Association	12.959	1	.000
N of Valid Cases	100		

Table 4.13.1 Showing Relationship between Gender and Sexually Active

4.13.1 Gender and being sexually active

A Chi-square test was performed to determine whether being sexually active was distributed differently across gender. There was a statistically significant association between being sexually active and gender ($\chi^2(2) = 17,7; p < 0,001$). The results of this study are congruent with other studies that showed that young girls are more sexually active than their male counterparts (NACA, 2006, BAIS II, 2004 & BAIS III, 2008).

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.699(a)	2	.000
Likelihood Ratio	18.546	2	.000
Linear-by-Linear Association	12.959	1	.000
N of Valid Cases	100		

Table 4.13.2 showing the relationship between gender and HIV test

4.13.2 Gender and HIV test

A Chi-square test was performed to determine whether taking a HIV test was distributed differently across gender. There was a statistically significant association between HIV testing and gender ($\chi^2(2) = 17,7; p < 0,001$). More females (75.4%)

went for HIV testing compared to 36.1% males in the past 12 months. From the male side, 63.8 % report not to have gone for an HIV test in the last 12 months as compared to 24.5 % who have not gone for the test.

Gender inequality which is embedded in most heterosexual relationships, is one of the critical determinants of continuing spread of HIV in Botswana (UNAIDS, 2009). Although males are shown to be equally sexually active as the female in the results of this study, the above reveal or suggest unequal power relations between the two; where males do not necessarily see the need to test for HIV as females do. In some instances, men forbid women to test for HIV test, even when there is evidence which strongly suggest women’s vulnerability to HIV (UNAIDS, 2009). One other explanation could be that males seem to have limited participation and involvement in Sexual and Reproductive Health programmes that are usually available in health facilities (MoH, 2002).

	<u>Value</u>	<u>Df</u>	<u>Asymp. Sig.</u> <u>(2-sided)</u>	<u>Exact Sig.</u> <u>(2-sided)</u>	<u>Exact Sig. (1-</u> <u>sided)</u>
<u>Pearson Chi-Square</u>	<u>10.356(b)</u>	<u>1</u>	<u>.001</u>		
<u>Continuity</u> <u>Correction(a)</u>	<u>9.056</u>	<u>1</u>	<u>.003</u>		
<u>Likelihood Ratio</u>	<u>10.623</u>	<u>1</u>	<u>.001</u>		
<u>Fisher's Exact Test</u>				<u>.002</u>	<u>.001</u>
<u>Linear-by-Linear</u> <u>Association</u>	<u>10.276</u>	<u>1</u>	<u>.001</u>		

Table 4.13.3 showing relationship between age and sexually active

4.13.3 Age group and Sexually Active

A Chi-square test was performed to determine whether being sexually active was distributed differently across age groups. There was a statistically significant association between being sexually active and age ($\chi^2 (1) = 10,36; p < 0,01$). The observed trend shows that the age group of 19-24 were more active compared to the

age group of 14-18. This could mean that young people generally starts sexual debut is around 19. BAIS III (2008), also show a low 3.5% of young people of age group 15-24 who have had sexual intercourse for the first time before the age of 15.

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.454(a)	2	.483
Likelihood Ratio	1.798	2	.407
Linear-by-Linear Association	.142	1	.707
N of Valid Cases	100		

Table 4.13.4 showing the relationship between age group and HIV test

4.13.4 Age Group and HIV test

A Chi-square test was performed to determine whether going for an HIV test was distributed differently across age groups. There was no statistically significant association between HIV testing and age ($\chi^2 (2) = 1,45; p= 0,48$). The older and younger age group were equally likely to go for HIV testing. This may be due to the fact that HIV Aids testing and counselling facilities are generally conducive for young people as more campaign have been made for youth friendly facilities. The results could also mean that young people have realised the importance of testing as way of curbing and preventing transmission from one person to another. Although, the Botswana National Policy on HIV and AIDS (2006), states that young people who have not reached age 16 have to get parental consent to go for an HIV, young people less than 16 seem to be benefiting from the HIV programs as they take courage and the initiative to test for HIV.

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.861(a)	4	.012
Likelihood Ratio	13.921	4	.008
Linear-by-Linear Association	.796	1	.372
N of Valid Cases	100		

Table 4.13.5 showing the relationship between employment status and HIV test

4.13.5 Employment Status and HIV test

A Chi-square test was performed to determine whether going for an HIV test was distributed differently across employment status. There was a statistically significant association between going for a HIV test and employment ($\chi^2(4) = 12,86; p < 0,05$). Those who were unemployed had a higher rate of testing for HIV in past 12 months compared to those that were employed. This may be due to the fact that unemployed youth have ample time to test, whereas their employed counterparts have to seek permission from authorities to go for an HIV test. Another explanation could be that the age group 14-18 (that are mostly students from the sample) are considered minors by the laws of Botswana and need parental consent to test for HIV.

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.852(a)	4	.028
Likelihood Ratio	12.808	4	.012
Linear-by-Linear Association	9.838	1	.002
N of Valid Cases	98		

Table 4.13.6 showing the relationship between STD and HIV test

4.13.6 HIV Test and STD's

A Chi-square test was performed to determine whether going for an HIV test was distributed differently across having a history of STDs. There was a statistically significant association between going for a HIV test and having a history of STDs ($\chi^2(4) = 10,85; p < 0,05$). Those who tested for HIV in the past 12 months reported significantly less of history of STD's compared to those who have not tested for HIV. Twenty nine percent of the young people who tested for HIV in th past 12 months reported no history of sexually transmitted disease. Comparatively, 70.1% of those who did not test for HIV in the past 12 months have a history of STD. This is consistent with what most studies have identified: sexually transmitted diseases potentially increase the chance of one to be infected with HIV because of non-preventive behaviours such as not using a condom consistently (BAIS III, 2008 & MoH, 2002). (See Table 4.13.6)

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	22.865(a)	4	.000
Likelihood Ratio	10.185	4	.037
Linear-by-Linear Association	5.981	1	.014
No of Valid Cases	98		

Table 4.13.7 showing the relationship between Sex in 12 month and HIV test

4.13.7 Sex in 12 months and HIV test

A Chi-square test was performed to determine whether having had sex in the last 12 months was distributed differently across going for an HIV test. There was a statistically significant association between going for a HIV test and having having had sex in the last 12 months ($\chi^2 (4) = 22,86; p < 0,001$). Those who were sexually active in the past 12 months had gone for a HIV test more often than those who were not sexually active. This means that youth who are sexually active have a need to go for an HIV test, as compared to those who are not sexually active and have little reason to go for an HIV test. (See Table 4.13.7)

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	49.237(a)	6	.000
Likelihood Ratio	8.974	6	.175
Linear-by-Linear Association	6.865	1	.009
N of Valid Cases	99		

Table 4.13.8 showing the relationship between Education and partner more than ten years

4.13.8 Education and Sexual Partner more than ten Years

A Chi-square test was performed to determine whether having sex with a partner who is ten years older was distributed differently across level of education. There was a statistically significant association between having sex with a partner who is ten years older were and level of education ($\chi^2 (6) = 49,23; p < 0,001$). The higher the level of education, the likelier that they may have a partner older than 10 years. The findings might mean that at higher institutions of learning young people feel grown up and

mature and have a higher likelihood of forming relationships with older partners. Another reason could be young people with highest education prefer older partners who can support them financially in order to buy fashion gadgets such as computers, cellphones and other icons of modernity. According to NACA, (2004) the older, better resourced men and women prey on sexually naïve or economically dependent girls and boys hence in this study about 20% of participants seemed to be caught in practices (See Table 4.13.8).

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.697(a)	3	.296
Likelihood Ratio	4.854	3	.183
Linear-by-Linear Association	.876	1	.349
N of Valid Cases	99		

Table 4.13.9 Table showing the relationship between gender and partner more than ten years

4.13.9 Gender and Sexual Partner more than ten years

A Chi-square test was performed to determine whether having sex with a partner who is ten years older was distributed differently across gender. There was no statistically significant association between sex with a partner who is ten years older and gender ($\chi^2(3) = 3,69; p = 2,96$). The results show that whether a participant was female or male did not appear to be more prone to have a partner who is ten years older than their age. The results of this study differ with other studies (MoH, 2002, NACA, 2006, and BAIS III, 2008) which state that young women are usually vulnerable to have intergenerational sexual relations than their male counterparts due to cultural practices such as giving them in marriages while there are still young. This observation may be to the fact that the population sample in this study predominantly live in the city, and therefore both girls and males may be affected by this practice in relatively the same way. According to the NACA (2006), intergenerational sexual relations between older men and younger women are believed to explain the higher rates of infection seen in young people, especially among young females. (See Table 4.13.9)

CHAPTER 5: RESULTS DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter entails the discussion of the study results, the conclusion and the recommendations from the results. The study was conducted to understand the difference (if any) between well-structured and non-structured families in terms of predisposing youths aged 14-24 in Gaborone to certain sexual risk factors associated with HIV infection. The findings of this study are restricted to the following risk factors: unsafe sex (addressed by questions 6 and 8 and 11); having multiple sexual partners (addressed by questions 4, and 5); having unprotected sex (addressed by questions 6, 8, 10 and 11); having sex for money (addressed by questions 3 and 9).

5.2 Demographic Characteristics

Almost half of the participants (55%) came from well-structured families and 45% came from non-structured families. The age groups were well balanced with 52% in age 19-24 and 48% aged 14–18 years. The sampled population comprised slightly more females (52%) and 60% of participants have attained secondary level education. Most participants were still students (59%) while 29% of the participants were out of school youth and unemployed. Table 4.1 gives a summary of the demographic characteristics of the participants.

5.3 Question 1

Figure 4.1.2 summarises the total participants who answered yes (76.6%) to sexually active question and those who answered no (23.4%) to question 1 (Are you sexually active?). However, family structure did not appear to make a significant difference for the risk factors associated with HIV infection. There was no evidence of a significant relationship between family structure and sexual activity. From non-structured family, 74.1 % of them report to be sexually active while 78.6% from well-structured family admitted to be sexually active. Only 25.9 % from non-structured family reported not to be sexually active compared to 21.4% from well-structured family. The findings confirm that a high number (76.6%) of the total sample population in this age group are sexually active compared to 23.4% of those who are not sexually active. This

result is consistent with most studies that categorise young people of age group 14-24 one of high-risk population groups. Botswana AIDS Impact Survey, (2008) shows the lowest incidence rate among young people aged 14-19, but the rate peaks sharply around the age 20-24 which is congruent with the results of this study.

5.4 Question 2

The results show that there was no significant relationship between family structure and sex in the last 12 months. Of those who are sexually active, 74.4% from non-structured families admitted that they had sex in the last 12 months compared to 69.1% from well-structured family. Sixteen point three percent from non-structured family denied having sexual activity in the past 12 months as compared to 29.1 % from well-structured family. However, this results show that a high number young people from both families have had sex in the past 12 months still proving how highly sexual active the youth are.

5.5 Question 3

In this question, the results showed that there was no significant relationship between family structure and sex in exchange for money. Only 16.2 % of the participants from non-structured family have admitted to have had sex in exchange for money while 5.5 % from well-structured structured have agreed to the same. Majority of participants 79% and 81.8% from non-structured and well-structured family respectively have denied ever having sex in exchange for money. Seventeen point four percent of participants have answered as not sure; 4.7 % from non-structured and 12.7% from well-structured family. Although many studies have proven that family members or children from poor families, or single parents or child headed families are likely to indulge in risky behaviours to support their basic needs (Groenewald, 2007, NACA 2002, UNAIDS, 2008), the results of this study show otherwise. These results could be different from because the socioeconomic status was not assessed by the study. Rather the presence or absence of one parent in one's family was used to categorise the participants.

5.6 Question 4

There was no significant relationship between family structure and having a non-regular sexual partner. About 20% from each family structure admitted sex with a non-regular partner compared to 67 % from each family structure who denied it. Eleven point six percent from non-structured family said they were not sure as compared to 10.9 %. One point eight percent of the participants from well-structured family did not answer the question. Like question 3, the results of this question show that having non regular sexual partner is not dependent on the family structure of a participant. But rather, participants at this stage age group are likewise in a vulnerable state of having non regular sexual partners. This is congruent with BAIS III (2008), which reports a high percentage of 38.6 of young people aged 15-24 who have sex with a non-marital, non-cohabiting sexual partner in the last 12 months.

5.7 Question 5

From non-structured family 34.9 % admitted to have had sex with more than one sexual partners compared to 21. 8% from well-structured family. The probability value is more than 0.05 and was not statistically significant. This shows that there is no significant relationship between family structure and this risk factor. The results show that 62.8 % of those who are from non-structured family denied having sex with more than one sexual partners as compared to 78.2% of their counterparts from well-structured families. Only 2.3% from non-structured answered as not sure. The results here show that more participants from non-structured families have had sex with more than one sexual partners compared to participants from well-structured families. The result is consistent with UNDP (2001) that the young people from these families [orphaned children, or youth from families with no or single parents] could be involved in risky lifestyle because they are looking for basic needs through sex sale, or having multiple sexual partners.

5.8 Question 6

In terms of having had unprotected sex with someone with an unknown HIV status, 23.3 % of participants from non-structured family answered in the affirmative as compared to 25.5 % from well-structured family. There was no significant relationship between family structure and this factor. From a non-structured family,

72.1% answered in the contrary while 61.6% from well-structured also denied having sex with someone of unknown HIV status. Only 4.7 % from non-structured families answered as not sure. However, we see from both family structures that more than 20% of the participants have risked having sex with a person with unknown HIV status. Young people seem, according to these results to have a tendency of being involved in risky behaviours, even when there is a known risk of contracting HIV. Although the reasons are not explicitly known, there might be some sort of explanation to this behaviour. In her work, 'The Social and Cultural Construction of Sexual Risk by Youth in Botswana', Ball (1996) describes how young people define risk in their own social and cultural milieu. Ball describes adolescence as a risk taking phase and those who do so might be regarded as successful among peers hence influence one another. Behaviours that are termed risky, especially health risks might be among youth termed or labelled as sign of success and may serve as an explanation pertaining to the results to question 6.

5.9 Question 7

There was no statistical significant relationship between family structure and testing for HIV in the past 12 months. Fifty four point five percent of those who came from well-structured family had gone for HIV test in the past 12 months as compared to 58.1 % from those who are from well-structured family. From a non-structured family, 41.9 % of the participants have reported that they have not done an HIV test, as compared to 43.6% from a well-structured family. Only 1.8 % had answered as not sure from well-structured family. More than half of the participants from each family structure have taken a step to test for HIV, which shows that young people are in the habit of testing for HIV as a way of prevention. This result is consistent with what BAIS III found, about young people belonging to age group 15-24, that most of them can identify correctly ways of preventing sexual transmission HIV and actually take a step to take a test for it.

5.10 Question 8

Family structure did not show any statistically significant relationship with being treated for a sexually transmitted disease. Twenty-one percent of the participants from non-structured family have had sexually transmitted disease as compared to only

18.2% from well-structured family. A higher number of participants have denied having been treated for sexually transmitted disease; 76.7 % from non-structured family and 78.2 % from well-structured family. About two percent of the participants from non-structured family and 3.64% from well-structured answered the question as 'not sure'.

Many studies have identified the presence of a sexually transmitted disease to potentially increasing the chance of one to be infected with HIV (MoH, 2002, NACA, 2006 and UNAIDS, 2008). The results above show about 20% from each family structure have reported having been treated for sexually transmitted disease.

5.11 Question 9

From this question, there was no significant relationship between family structure and having partners 10 years older. There were 16.3 % of participants from non-structured family that admitted to have partners that are ten years older than them, as compared to 20.0 % from a well-structured family. Almost the same number from each family structure (81.1 % and 78.2 % from non-structured and well-structured respectively) has denied this practice. According to the NACA (2006), intergenerational sexual relations between older men and younger women are believed to explain the higher rates of infection seen in young people, especially among young females. Intergenerational sex also involves younger men and older women. According to NACA (2004), the older, better-resourced men and women prey on sexually naïve or economically dependent girls and boys hence in this study about 20% of participants seemed to be caught up in the practise.

5.12 Question 10

The findings of this question show 9.3 % from non-structured family have answered in the affirmative and only 1.8 % from well-structured family has also answered in the affirmative. Ninety percent of them from non-structured and 94% from non-structured and well-structured family respectively have denied occasional sex for money. Only 1.8% from well-structured has answered as not sure. Deducted from these results, five times more participants from non-structured family are involved in sex sale, than those who are from well-structured families. There was no significant relationship

between family structure and this risk factor. Although there was no significant relationship, participants from non-structured family had proven to be five times more involved in sex for money than those from well-structured family. These results are consistent with NACA (2006) observation that young people from these families could involve in risky lifestyle because they are looking for basic needs through sex sale and are also involved in unsafe sexual relations in order to support their siblings or family members.

5.13 Question 11

A percentage of 18.6% of participants from non-structured family showed that they have had unprotected sex under the influence of alcohol as compared to about half (9.1%) from well-structured family. Although almost twice the number of participants from non-structured family answered in the affirmative as from well the structured family, there was no statistically significant relationship between family structure and this risk factor. There were 76.6 % of participants from non-structured family as compared to 90.9 % from well-structured family who denied having had sex under the influence of alcohol.

5.14 SUMMARY OF THE RESULTS

The findings show that there is no difference between well-structured and non-structured families in terms of predisposing youths to certain sexual risk factors associated with HIV infection. None of the probability values between family structures and the risk factors was statistically significant. A conclusion is therefore made that whether one is from either a non-structured family (a one parent headed family, or child headed family) or well-structured (a family with both parents raising children together) does not predispose young people to HIV infection. Thus, the null hypothesis is accepted, i.e. there is no difference between well-structured and non-structured families in terms of predisposing youths to certain sexual risk factors associated with HIV infection in Gaborone.

However, there are other behavioural patterns and relationships between variables that have been established by this study. The study has shown that in higher institutions of

learning such as the University of Botswana, young people are more involved in intergenerational sexual relations than those who are in secondary schools. Lesser males have shown not to test for HIV as compared to their females counterparts, young people aged 19-24 have shown to be more sexually active than young people aged 14-18. Young people who are employed also seem not to be testing for HIV as often as those who are not employed. The results of the study have also shown that young people who report a history of sexually transmitted diseases have also not gone for an HIV test in the past 12 months. Young girls have also proven to be more sexually active than their male counterparts.

5.15 RECOMMENDATIONS

According to the results of this study, there was no significant difference for family structure in terms of predisposing participants to the risk factors associated with HIV infection. The researcher therefore recommends, based on these findings, that educational campaign on HIV/AIDS should not discriminate young people by family structure, or any social background that they may have. HIV campaigns should rather be directed to the youth in general as they have proven to be highly vulnerable (Figure 4.1.2). However, young girls have shown to be more sexually active than their male counterparts (Table 4.13.1) and this observation calls for more empowerment of the girl child in order to minimise chances of engaging in unsafe sexual relations

The results show that males are less likely to go for an HIV test than females. Recommendation is made that campaign for HIV testing be intentional in targeting males as they seem to be lagging behind in this matter. On the other hand, young females have also proven to be more sexually active than their male counterparts. This suggests that young people of different gender face different challenges, therefore there is a need to tailor make interventions based on the factors they face the most.

The results also show that the older the age group the higher the risk to get HIV infection (Table 4.13.3). In order to address this, educational campaign on issues of HIV should be intensified in age groups 19-24. The results also show age group 14-18 to be less sexually active, hence more should be done to encourage young people at

this age group to minimise the risks associated with HIV infection. Educating and empowering the youth at an early and tender age can significantly minimise the prevalence rate and incidence rate in older age groups

Employed youth seem not to be testing as frequent for HIV as their unemployed counterparts. There is a need to make intensive campaign in the workplaces for employees to test for HIV test especially the young people. There is also a need to educate the employers to release employees for HIV testing. Employers should also be taught how HIV and productivity in the workplace are related in order to appreciate the importance of giving employee time off to test for HIV.

The results show that the higher the level of education, the likelier that they may have a partner older than 10 years. More and deliberate educational efforts should target issues and risks surrounding intergenerational sexual practices. These educational efforts should be intensified in higher institutions of learning as it has been proven by the results.

5.16 CONCLUSION

From the results, it seems that young people are generally sexually active, and may be at risk of contracting HIV as a result of some risk factors. These include factors such as having non regular sexual partners and having unprotected sex with someone whom their HIV status is not known. While these behaviours (such as having sex with regular partners and having unprotected sex) and trends are termed very risky, it is also important to recognise that young people are individuals that can make right choices and can stay uninfected- irrespective of their family structure. Parents face different opportunities and risks in rearing their children because of their [children's] mental and physical make-up as well as the social environment they inhabit (Garbarino, 1992). On the other hand, young people are caught between the expectations of both traditional and modern life and their decisions about sexual relationships are influenced by their surrounding (Ball, 1996). According to this study, parents (whether staying together, married or single) do not determine the outcome of their children especially in vulnerability to HIV infection. The result of

the study shows that vulnerability to HIV infection is not related to the family structure in which the youth are raised.

5.17 LIMITATIONS OF THE STUDY

Research that deals with sexuality face limitations especially in Setswana Culture. Sex and sex issues are considered personal and private part of peoples lives and limitations were expected.

In Setswana culture, it is considered disrespectful to ask or discuss with older persons about sexual issues. As a researcher, I faced this challenge during the process of asking for permission to continue with the study from local authorities because there were older than me; for example in dialogue with school heads and community leaders there was a bit a of hesitation from the side of the local authorities since the subject was about sex and sexuality.

The population sample of the study was not randomly selected, those who wanted or who consented to the study did so voluntarily, therefore the results of the study cannot be generalised to the entire population of youth in Gaborone. The youth who consented to complete the questionnaires were given private space to complete without the researcher or the research assistant to look at what they were writing unless they had a question to ask. This was done to create a comfortable and a non threatening environment for the participants.

At times the youth preferred to complete questionnaires in groups, so the answers to the questionnaires could be biased; exaggerated or underestimated depending on the individual or the friends they were found with. Measures to minimise bias were taken but could not be eliminated completely.

Being an outsider (not a family member or school teacher) has proven to be beneficial (data was somewhat objective) as the participants perceived that I have little vested interest in their personal information.

Although the subject of sex between youth and adults is regarded as taboo, young people seemed to enjoy the subject among themselves, so there was a sense of enthusiasm as they study was being introduced to them. This could have influenced results somehow.

Out of school youth, especially among age group 14-18, had difficulty completing the questionnaires hence needed translation to Setswana. Otherwise most participants did not need any help with completing the questionnaires. In some instances, misinterpretation of the questions could have occurred.

The specific age of the participants was not solicited by the questionnaire. Only age group was determined, therefore making the results limited in terms of associating specific age with other factors. For example, the age at which young people start sexual activities could not be determined.

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APPENDIX I

QUESTIONNAIRE

COMPARING FAMILY STRUCTURE AND SEXUAL RISK FACTORS ASSOCIATED WITH HIV INFECTION OF YOUNG PEOPLE [AGED 14-24] IN GABORONE

DEMOGRAPHIC INFORMATION

INITIALS: _____

AGE:

14-18	19-24
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GENDER

FEMALE	MALE
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EDUCATIONAL BACKGROUND

PRIMARY	SECONDARY	TERTIARY
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EMPLOYMENT STATUS

EMPLOYED	UNEMPLOYED	STUDENT	SELF EMPLOYED
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FAMILY STRUCTURE

Please tick the type of family structure that best describes your family

- Well-structured Family defined as: a family with both mother and father raising children together**
- Non structured family defined as: a family with either an absence of mother or father (or both), family could be headed by a child or a grandparent**

Risk Profile questions:

1. Are you sexually active?

Yes

No

If yes, then answer the following questions:

2. I have had sex in the last 12 months.

Yes

No

Not sure

3. I have had sex with someone who I know has given money in exchange for sex

Yes

No

Not sure

4. I have had non-regular sexual partners in the last 12 months.

Yes

No

Not sure

5. I have had sex with more than one partner in the last 12 months.

Yes

No

Not sure

6. I have had unprotected sex with someone's HIV status I don't know.

Yes

No

Not sure

7. I have gone for a HIV test in the last 12 months.

Yes No Not sure

8. I have been treated for a sexually transmitted disease.

Yes No Not sure

9. I have had sex with someone who is more than 10 years older than me

Yes No Not sure

10. I occasionally have sex for money

Yes No Not sure

11. I have had unprotected sex under the influence of alcohol

Yes No Not sure

APPENDIX II

P O BOX 81961

Gaborone

27 February 2010

The Head teacher

Gaborone Secondary school

Box 100

Gaborone

Dear Sir

REQUEST FOR PERMISSION TO CONDUCT A STUDY IN YOUR SCHOOL

I would like to ask for permission to conduct a study among the students in your school. Currently I am working with Botswana-Harvard Partnership in Princess Marina Hospital, and a student at the University of Stellenbosch.

I am studying to attain a Masters of Philosophy Degree in Management of HIV/AIDS. As part of this course; I am expected to conduct a study in partial fulfilment and requirement of this degree. The main objective of my study is to find out if there is any association between ones family structure with factors associated with to HIV infection among youth aged 14 -24.

I would be happy if my request is favourably considered.

Thank you.

Yours faithfully,

Gaseboloke Mothowaeng
P O BOX 81961
Gaborone

27 February 2010

The councillor
Gaborone Town Council
P BAG 0092
Gaborone

Dear Sir

REQUEST FOR PERMISSION TO CONDUCT A STUDY IN OLD NALEDI

I would like to ask for permission to conduct a study among YOUTH in old Naledi location. Currently I am working with Botswana-Harvard Partnership in Princess Marina Hospital, and a student at the University of Stellenbosch.

I am studying to attain a Masters of Philosophy Degree in Management of HIV/AIDS. As part of this course; I am expected to conduct a study in partial fulfilment and requirement of this degree. The main objective of my study is to find out if there is any association between ones family structure with factors associated with to HIV infection among youth aged 14 -24.

I would be happy if my request is favourably considered.

Thank you.

Yours faithfully,

Gaseboloke Mothowaeng

P O BOX 81961

Gaborone

27 February 2010

The Director

Student Welfare

University of Botswana

P /Bag 0022

Gaborone

Dear Sir /madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY IN UNIVERSITY

I would like to ask for permission to conduct a study among the students in the University. Currently I am working with Botswana-Harvard Partnership in Princess Marina Hospital, and a student as well at the University of Stellenbosch.

I am studying to attain a Masters of Philosophy Degree in Management of HIV/AIDS. As part of this course; I am expected to conduct a study in partial fulfilment and requirement of this degree. The main objective of my study is to find out if there is any association between ones family structure with factors associated with to HIV infection among youth aged 14 -24.

I would be happy if my request is favourably considered.

Thank you.

Yours faithfully,

Gaseboloke Mothowaeng