

# HIV/AIDS Knowledge, Attitudes, Perceptions and Risky Sexual Behaviour of Women in Lobatse Botswana.

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## ABSTRACT

HIV/AIDS has become a global concern and the considerable and disproportionate impact of the disease on women in Botswana, as elsewhere in Africa, has reached a stage where it threatens the social and economic well being of the human society. Therefore this study undertook to examine the levels of HIV/AIDS knowledge, attitudes, behaviour and practices among women in Lobatse, Botswana by interviewing 145 women through questionnaires.

The findings generated from the study suggesting that although the vast majority of respondents are aware of HIV/AIDS and the principal modes of transmission some aspects of their sexual lifestyles, practices and perceptions remain a cause for concern.

A good number of the respondents believe that medical solutions exist to the problem of HIV/AIDS. These kinds of misconceptions are certainly a cause for concern. The age at first sexual intercourse is relatively young and this can be explained by the cultural and social norms in the community. Condom use is reportedly inconsistent and low, a contradiction with the observed knowledge levels, only confirming further that knowledge does not necessarily translate into action.

Respondents also reported tendencies towards discriminatory practices and attitudes against people infected with HIV/AIDS. This may be a contributory factor leading people to shy away from knowing their status and preferring not to tell anyone in case they know. This calls for more educational interventions, to demystify the disease and curb the arising stigma.

The findings also confirm that whereas a lot of effort has been put in information and education, the more difficult and urgent attention should be in translating the knowledge and information into the required behaviour change if we are to win the war against HIV/AIDS.

## OPSOMMING

MIV/VIGS het 'n wêreldwye kommer geword en die aansienlike en oneweredige impak van die siekte op vroue in Botswana, soos elders in Afrika, het 'n stadium bereik waar dit die maatskaplike en ekonomiese welsyn van die menslike samelewing bedreig. Hierdie studie word dus onderneem om die vlakke van MIV/VIGS kennis, houdings, gedrag en praktyke onder vroue in Lobatse, Botswana, te ondersoek deur onderhoude met 145 vroue te voer, deur middel van vraelyste.

Die bevindinge verkry uit hierdie studie, dui daarop dat, alhoewel die oorgrote meerderheid van die respondente bewus is van MIV/VIGS en die vernaamste maniere van oordrag van die siekte, hulle lewenstyl, gewoontes en insig steeds 'n bron van kommer bly.

'n Groot aantal respondente glo dat mediese oplossings bestaan vir die probleem van MIV/VIGS. Hierdie soort wanopvatting is beslis 'n rede tot kommer. Die ouderdom by eerste seksuele omgang is redelik jonk en kan toegekryf word aan kulturele en sosiale standaarde. Die gebruik van kondome is volgens wat berig word, laag en teenstrydig met die kennisvlakke wat waargeneem is. Dit bevestig net weer dat kennis nie noodwendig voortvloei in gedrag nie.

Respondente het neigings getoon tot diskriminerende praktyke en houdings teenoor mense wat geïnfecteer is met MIV/VIGS. Dit kan 'n bydraende faktor wees wat daartoe lei dat mense nie hulle status wil weet nie en as hulle weet, hulle dit nie wil bekend maak nie. Dit vereis meer opvoedkundige ingrypings om die raaiselagtigheid van die siekte en die ontstaan van stigma te bekamp.

Alhoewel daar baie moeite gedoen word om inligting en opvoeding aan mense te gee, moet daar meer aandag gegee word aan hoe om die kennis en inligting te omskep in gedragsverandering, as ons die oorlog teen MIV/VIGS wil wen.

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## **1. Introduction**

The HIV/AIDS epidemic is a universal problem throughout the world, with its consequences being felt mainly in the social demographic and economic areas. It is estimated that there were 33.3 million people living with HIV at the end of 2009 compared with 26.2 million in 2006 UNAIDS (2010). UNAIDS further reports that Sub-Saharan Africa still bears an inordinate share of the global HIV burden, although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. In 2009, that number reached 22.5 million, 68% of the global total. UNAIDS (2007) posts that Sub-Saharan Africa has more women than men living with HIV. By the end of 2007, out of an estimated 30.8 million adults worldwide, half were women and it is suggested that 95% of these women live in developing countries.

UNAIDS (2000) reports that the following factors and forces exist that restrict people's autonomy, and more especially women leaving them particularly exposed to HIV infection or vulnerable to needless suffering once they are infected: Intolerance of racial, religious or sexual minorities; discrimination against people with known or suspected HIV infection; lower status of women; abuse of power by older or wealthier individuals; scarcity of HIV counseling, testing facilities and of condoms; lack of care and support for those infected or affected with HIV; poverty that leads to prostitution, domestic violence and rape; military conflict and labor migration which split up families; lack of respect for the rights of women and children; freedom from inhuman or degrading treatment and the right to privacy and confidentiality.

UNAIDS (2010) reports that in 2009 there were an estimated 300 000 adults living with HIV in Botswana. Considering that Botswana's population is below two million, the epidemic has thus reached disturbing proportions. The country has an estimated adult HIV prevalence of 24.8% among 15-49 year olds the second highest in the world after Swaziland.

This research on knowledge, attitudes and behaviour towards HIV/AIDS among women in Lobatse was carried out with the aim of getting a better overview of their knowledge, attitudes and behaviour towards HIV/AIDS with the following specific objectives:

- To assess the level of knowledge about the different aspects of HIV/AIDS;
- To examine the attitudes of the women towards HIV/AIDS;

- To assess their sexual behaviour and practices and the scope for risky practices and
- To assess their attitudes towards those infected by HIV/AIDS.

### **1.1 Research problem**

The reason for conducting this study is to assess and establish the knowledge, attitudes and perceptions of women in Lobatse, Botswana, to HIV/AIDS and to explore the factors that drive them to engage in risky sexual behaviour. There appears to be a difference between knowledge about HIV/AIDS and behaviour change because despite the numerous education and prevention campaigns, only minimal results have been noted.

### **1.2 Rationale for the study**

HIV/AIDS is an epidemic of catastrophic magnitude with deadly consequences. HIV/AIDS is a disease that kills millions globally. In 2000, UNAIDS stated that AIDS caused the deaths of an estimated 3 million people worldwide. Approximately 95% of the global total of people with HIV/AIDS live in the developing world, with twenty one countries with the highest HIV/AIDS prevalence being in Africa (Centre for Disease Control, 2001).

The Botswana Sentinel Surveillance Report of 2009 estimated that the national overall HIV prevalence amongst 15–49 years old antenatal women in the public health clinics is 31.8%. The national HIV prevalence amongst the women surveyed has shown a decline of prevalence from 36.2% in 2001 to 31.8% in 2009 (Ministry of Health 2009). Despite this decline there is a need to establish the differences in the knowledge, attitudes and perceptions so that more appropriate strategies are crafted to help combat the epidemic especially among women, who are the most vulnerable group.

By exploring these issues, the researcher tried to gain a better understanding of the knowledge, attitudes and perceptions of women in Lobatse, thereby unravelling the mystery that has hindered the adoption of safer sexual practices. Based on the outcomes of this study new programmes, targeting the population under study, could be developed that will take the new findings into account.



### **1.3 Aim of the study**

The main aim of this research is to determine the knowledge, attitudes and perceptions with regards to HIV/AIDS among women aged 15-49 in Lobatse and factors that influence their sexual behaviour. This research will:

- investigate the knowledge, awareness and perceptions of HIV/AIDS among women aged 15-49;
- investigate sexual attitudes and behaviours of the women in Lobatse;
- investigate the socio-demographic factors that influence their sexual behaviour, knowledge of HIV and HIV risk behaviour; and
- make recommendations to the National AIDS Co-ordinating Agency, policy and programme workers and other interested parties, so that more specific interventions targeting women can be developed.

### **1.4 Research questions**

To guide the research, the following research questions were formulated:

1. What is the level of knowledge and perceptions regarding HIV/AIDS?
2. How does the knowledge and perceptions influence the women's attitudes towards HIV/AIDS and influence their sexuality?
3. What factors influence the risky sexual behaviour among the women?
4. What can be done to try and curb the HIV/AIDS epidemic in Botswana in relation to the knowledge, attitudes and perceptions to HIV and the risky sexual behaviours among women?

## **2. Literature review**

The HIV/AIDS infection rate in Botswana is escalating at a very alarming rate despite all HIV/AIDS publicity and preventive services. The recent UNAIDS statistics indicate that 35.8% of the adult population in Botswana is infected, which is the highest prevalence rate ever recorded in the world. In Ngamiland West alone, out of 675 tests conducted in symptomatic people and few volunteers in Gumare Primary Hospital, from January 1988 to July 2002, 496 were positive, 74% of the tested cases (Republic of Botswana/UNDP, 2002).

Coetzee (2002) undertook a study on knowledge, attitudes, practice, and behaviour on HIV/AIDS in Botswana, Ngamiland West. The results of the study indicated that on average these communities were well informed about HIV/AIDS with the elderly being the least informed. They are aware of the real cause of HIV/AIDS, different modes of transmission as well as different measures one has to take to avoid infection. However, 35% of the respondents still hold onto misconceptions about HIV/AIDS. These include beliefs such as AIDS being caused by witchcraft, having sex with widows who have not undergone ritual cleansing or traditional doctors being able to cure HIV/AIDS. Half of the respondents could not differentiate between HIV infection and AIDS.

Coetzee further found that the common belief in Ngamiland West was that once you become infected you become sick, and therefore HIV/AIDS can only be caught from people showing signs of sickness. Almost half (48%) of the respondents were not aware of the risks involved in providing home-based care to AIDS patients. Some people were not aware of the preventative measures one has to take when handling the patients' body fluids, although 73% of the people thought of abstinence and condom use as the best method of preventing infection, but practically this is not happening. Forty percent (40%) of the respondents even indicated that once you are sexually active you could not refrain from having sex and completely ruled out abstinence from. 68% of them also indicated that they sometimes or never use condoms when having sex.

Tlou & Phaladze (2000) in their study *AIDS prevention for women in Botswana* also found that in the Botswana society, the elderly men rarely use condoms, and a woman can still not initiate condom use even when she thinks that she is at risk of being infected. Most of the men indicated that they do not like to use condoms as they interfere with their pleasure. Some stated that condoms have worms which cause diseases including HIV/AIDS, while others indicated that they are allergic to the lubricant used in condoms. Most female respondents indicated that they would like to use condoms, however never do so because their men usually refuse to do so.

The Botswana Multiple Indicator Survey (2000) focused on women's knowledge, attitudes, and sexual behaviour associated with the HIV/AIDS, interviewed 6 485 women aged 15-49 in 14 districts (Gaborone, Francistown, Lobatse, Selebi-Phikwe, Southern, South East, Kweneng,

Central, North-East, North West, Gantsi and Kgalagadi). The results showed that the awareness level on HIV/AIDS and condom use rate was high. However, accurate knowledge on the disease was still low. The Central Statistics Office (2001) conducted *The Botswana AIDS Impact Survey* on knowledge, attitudes, and sexual behaviour associated with the HIV/AIDS epidemic, with the findings that the awareness level on HIV/AIDS and condom use rate was high. However, accurate knowledge on the disease was still low.

Risky sexual behaviour was found to be common amongst the population. Precise estimates of sexual risk behaviours, AIDS knowledge and prevention behaviours, and other relevant indicators are however not clear and needs to be established. The Botswana-United States of America Project, (BOTUSA) conducted a study in 1999 to identify sexual risk factors for HIV infection in Botswana. There were 93 HIV positive and 42 HIV negative patients who participated in the study. It was evident from the research results that the respondents who were HIV positive and some HIV negative, believed that a man is like a bull and should not be confined to one pasture and some said that a woman should not refuse sex. The female participants also believed that men were largely unwilling and uninterested in HIV/AIDS education. Women said they always initiated the discussion with partners and were discouraged by their partners who think that women always want to control them.

BOTUSA (1999) conducted another study on knowledge, attitudes and beliefs regarding Tuberculosis Preventative Therapy (TBPT) for HIV-infected persons living in Botswana during 1999. The objectives of the study were to measure knowledge, attitudes and beliefs about TBPT and HIV testing and to identify patient characteristics and programme features that would maximise acceptance of TBPT. Tuberculosis accounts for 44% of deaths in adults who die of AIDS. TB prevention in persons living with HIV could improve the quality and duration of life. In Botswana, HIV prevalence and TB rates are among the highest in the world.

The results showed that the majority of the respondents from this study seemed to recognise the relationship between TB, sexually transmitted diseases (STDs) and HIV/AIDS, as they believed that TB caused HIV/AIDS. There was however a misconception about the causal relationship. Some respondents said that AIDS caused TB and some said that sex and STDs caused TB. Some

respondents were not sure of the causes of TB and HIV/AIDS. The majority of the respondents also knew that TB and HIV/AIDS could be asymptomatic. However not many respondents have taken an HIV test although the majority said that they were planning to take the test.

According to Tlou & Phaladze (2000) there were various misconceptions about the transmission of HIV/AIDS, which was believed that it could be spread through feces. Foreigners (makwerekwere) were blamed for the spread of HIV and the people further believed that pregnant women who sleep around during pregnancy transfer the virus to the child. The majority of the participants did not know about the VCT centres. The participants also thought that potential negative reaction to a positive HIV test could range from depression to suicide. Positive results were associated with death coming up soon as there is no cure for AIDS. They also feared the negative reaction from partners after being tested. Abandonment of a woman by the male partner was assumed to be a potentially common response and that is why HIV positive tests result is not disclosed. Women who are HIV positive are said to be unfaithful.

Abdool-Karim (2001) who conducted a Knowledge, Attitude Behavioural Perception study in Kwa-Zulu Natal sampled 327 women aged between 15-44 years found out that in spite of the high levels of knowledge among women; the knowledge did not influence their adoption of safer sex practices. The study found that 50% of the women did not believe that they had the right to safer sex practices such as refusing to have sex or insisting on condom usage while about 50% of the women believed that men had the right to multiple partners.

National AIDS Coordinating Agency (2003) undertook a baseline study on the knowledge, attitudes, behaviour and practices of young people in Gaborone. It involved a sample of 627 young people in Gaborone. Focus group discussions were held with young people, their parents and community leaders. The survey examined the socio-economic profile of the young people, their sources of information on AIDS, their knowledge and attitudes about AIDS and STDs. It also focused on views and behaviour regarding relationships, sexual behaviour, condom use and access to condoms. The results of the study confirmed that a considerable proportion of young people still lacked the necessary information on AIDS prevention.

### **3. Methodology**

#### **3.1 Measuring of risky sexual behaviour**

UNAIDS (2000) stated that risky sexual behaviour is a factor of the number and type of sexual partners from occasional partners. We will consider the length of the relationship, the nature of the relationship and the sexual network of the partner. Therefore a sexually active person demonstrates risky sexual behaviour if he/she meets at least one of the following conditions:

- One occasional sexual partner during the last twelve months and either engages in transactional sex, or has other sexual partners
- For married individuals, at least one extra-marital sexual partner, regular or occasional, during the last twelve months
- For unmarried individuals, at least two regular sexual partners

#### **3.2 Research design**

Polit, Beck & Hungler (2004) stated that a research design is a blue print for conducting a study that maximises control over factors that could interfere with the validity of the findings. According to Grove & Burns (2005), the design of a study is the result of a series of decisions made by the researcher concerning how the study will be implemented.

This study employed quantitative research, which according to Polit and Beck (2006) is a formal, objective and systematic process in which numerical data are used to obtain information about the world. This study employed quantitative research because the study aimed at measuring and quantifying factors relating to HIV/AIDS related knowledge, attitudes, perception, and sexual behaviour of women in Lobatse. This method is not very expensive and will also provide efficient and a rapid way of mapping out dominant sexual behaviour in the study population.

#### **3.3 Measuring instruments**

Data was gathered by the use of a structured questionnaire. The questionnaire consisted of several sections. General as well as specific questions were asked. The following aspects were covered.

- Biographical detail
- General knowledge of HIV and AIDS
- Knowledge of safe sex practices
- Attitudes to HIV/AIDS and those infected

### **3.4 Research setting**

Lobatse is located in the southern part of Botswana, 70 kilometres from the capital city, Gaborone. It lies along the flat bottom valley of the Peleng River and its tributaries. Lobatse has many agro-based industries which dominate the manufacturing sector of the town, with beef processing employing a fifth of the total labour force. Other industries include leather tannery, milling, brewery, and brick/tile manufacturing.

Lobatse has excellent linkages to the neighbouring countries of Namibia and South Africa both by road and rail. It is situated along the A1 national road to South Africa with the Ramatlabama border 50 kilometres away and Pioneer border only 7 kilometres away. Thus, the town also serves as a truck stop for truckers ferrying goods from or to Namibia or South Africa. Lobatse has a population of 43 562 people in 9 523 households. 19 487 male and 24 075 female, of this women aged 15-49 make up 60 % which is 14 447.

#### **3.4.1 Study sites**

The study was carried out in the western area of the town, in 2 adjacent neighbourhoods namely Peleng and Boswelatlou. They are high density areas, with a population of about 6 800. Most homes in Boswelatlou have most of the usual facilities in the houses, with designated social amenities like shops, sports fields etc, while in Peleng a majority of the houses are rather small, make use of outdoor toilet facilities and the residents collect water from communal stand pipes.

#### **3.4.2 Population**

This study was aimed at exploring the knowledge, attitudes, and perceptions of women between 15-49 years of age as this group has been identified as being the most vulnerable to HIV/AIDS. For the purpose of this study, the population consisted of 145 women from the two study sites which is roughly 10% of the total population.

### **3.5 Sampling**

The research studied a sample of women aged 15-49. The sample represented the broader population of women. It is important to note, that due to the scope of the study, it was not possible to use a sample that will be generalisable to the whole population, and therefore, the accuracy of the findings is only subject to the scope of this study.

Women aged between 15-49 years were approached and requested to fill the questionnaires from the two selected sites of Boswelatlou and Peleng. The first household was randomly selected in each site and thereafter every tenth household was visited in each site. In the case that there was no woman in the age category (15-49) found at the tenth household, another tenth household was selected. In each household if there were more than one eligible woman that could be interviewed, the researcher chose only one by cutting an equal number of paper pieces to the number of eligible women in the household, all of them will be marked NO except for one which will be marked YES and only the woman who picks the YES was interviewed.

### **3.6 Statistical analysis**

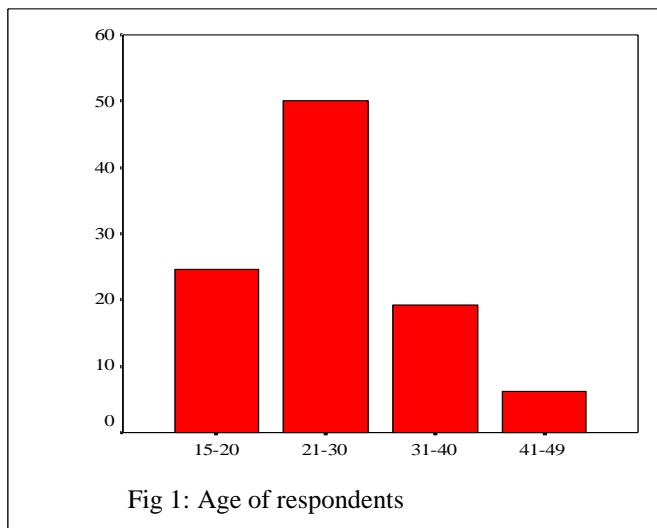
Quantitative data collected from the questionnaire were coded and processed using SPSS. Frequency tables, bar graphs, pie charts, cross tabulation were employed to allow for the efficient summary of all collected data and to allow for the determination of any significant differences between groups and the examination of relationships among the variables.

## **4. Results**

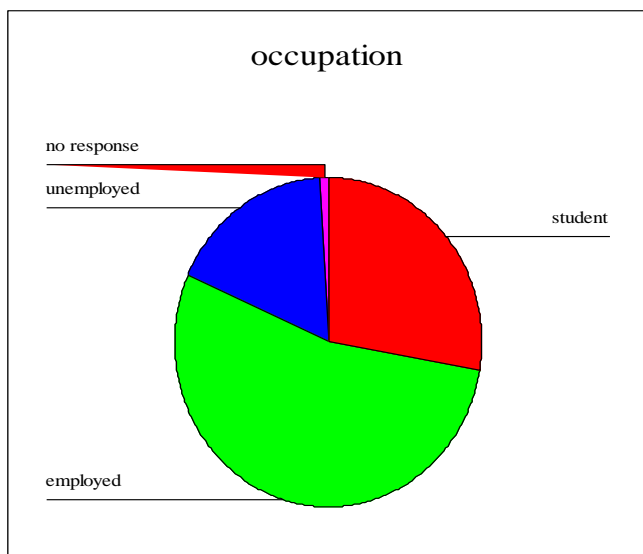
A total of 145 questionnaires were distributed and of these 137 were received back. This equals a response rate of 94%. During data preparation and cleaning, 7 questionnaires were found to be unusable and were therefore discarded. In these questionnaires some respondents say they have never had sex but later would respond that they have used a condom. In some a majority of the questions because of the somewhat sensitive nature were not answered while in some respondents either chose yes or no answers to all questions. This raised concerns on the integrity and reliability of such responses. The final number of useable responses was 130 which translated to a 90% response rate.

#### 4.1 Socio-demographic profile of the respondents

Of the 130 respondents, 61 were from Peleng and 69 were from Bosewelatlou. Of these 65 (50%) were from the age group 21-30 followed by the age group 15-20, which constituted approximately 25% of the respondents. These two groups made up the bulk of the respondents which shows that the population of the women in Lobatse is fairly young with just a handful of women between 40-49 years of age as depicted below.



Further analyses showed that 80% of the respondents were single and lived alone, while 15% were married and the remaining 5% were either divorced or separated. Of this population about 28% were students, 55% employed while 20% were unemployed as shown below.





## 4.2 General knowledge of HIV/AIDS

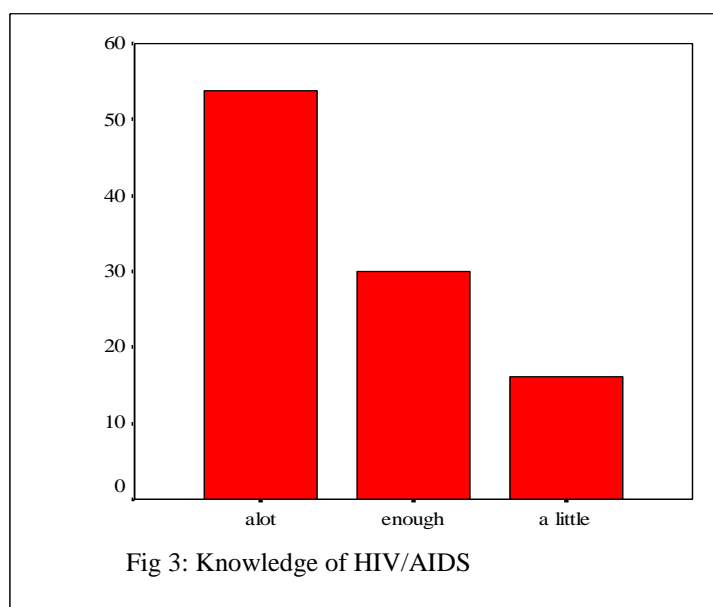
Critical to an understanding of the respondent's knowledge base about HIV/AIDS is a need to determine their awareness of the disease. Information was solicited from the respondents, if they had ever heard of HIV/AIDS and how much they thought they knew about the disease.

### 4.2.1 Heard about HIV/AIDS

97.7% of the respondents reported having heard about HIV/AIDS with both study sites reported a high awareness level. However, about 2.3% of the population, divided rather equally between both sites, reported they had never heard about HIV/AIDS. Though this is a small percentage, it shows that there may be some hidden populations that are still ignorant and this is a cause for concern given the gravity of the HIV/AIDS epidemic.

### 4.2.2 Self- reported knowledge

In response to how much they thought they knew about HIV/AIDS, the data revealed that 83.8% claimed they had substantial knowledge about HIV/AIDS. Of these 53.8% said they knew a lot and 30% thought they knew enough. 16.2% reported little knowledge, which may include, no knowledge as about 2% had earlier indicated they had not heard of HIV/AIDS. The 16.2% who indicated they had little knowledge of HIV/AIDS is too large a figure, especially when one considers the universality of HIV/AIDS and the threat it poses to the society.



### 4.2.3 Sources of HIV/AIDS information

Mass-media was the main source of their information about HIV/AIDS with 61.5% getting information from radio and television, 26,2% relied on the clinic, while 10% got information from friends as shown in table 1 below. This suggests there is still some stigma attached to HIV/AIDS as people are clearly not comfortable talking about it.

Table 1: Sources of HIV/AIDS information

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	radio	42	32.3	32.3	32.3
	television	38	29.2	29.2	61.5
	friends	13	10.0	10.0	71.5
	clinic	34	26.2	26.2	97.7
	no response	3	2.3	2.3	100.0
	Total	130	100.0	100.0	

### 4.2.4 Know anyone with HIV/AIDS?

More than 86% of the respondents indicated they knew persons who were living with HIV/AIDS and 14% were unsure. This is not surprising given the comparative stigma which surrounds HIV/AIDS.

### 4.3 Knowledge and awareness of HIV/AIDS

Since a general awareness of HIV/AIDS is believed to govern decision making and the promotion of safe behaviour the respondents were asked the following 4 questions:

- 1) Is there a difference between HIV and AIDS?
- 2) Does an HIV positive person have lower body resistance?
- 3) Is HIV/AIDS a major problem in Botswana?
- 4) Are more women infected with HIV/AIDS in Botswana than men?
- 5) Can HIV/AIDS be treated using ARVs?

The analysis of data indicated the vast majority of the respondents had correct knowledge on the matters except on question 5 as is shown in table 2 below. A discussion of all questions will follow.

Table 2: Knowledge and awareness of HIV/AIDS

	Is there a difference between HIV/AIDS?		Does an HIV positive person have lower body resistance?		Is HIV/AIDS a major problem in Botswana		More women are infected with HIV/AIDS in Botswana than men		HIV/AIDS can be treated using ARVs	
	Count	%	Count	%	Count	%	Count	%	Count	%
yes	106	81.5%	95	73.1%	116	89.2%	93	71.5%	79	60.8%
no	21	16.2%	34	26.2%	14	10.8%	29	22.3%	50	38.5%
NR	3	2.3%	1	.8%			8	6.2%	1	.8%
Total	130	100.0%	130	100.0%	130	100.0%	130	100.0%	130	100.0%

#### 4.3.1 Difference between HIV and AIDS

Given the misconceptions that exist about HIV and AIDS, respondents were asked whether there is a difference between HIV and AIDS. The majority (81.5%) reported correctly that there is a difference but 16.2% stated that there was no difference and 2.3% did not respond.

#### 4.3.2 Lower body resistance

73% of the respondents knew that a HIV positive person has lower body resistance, 26% stated that there was no impact of HIV on the body resistance while less than 1% remained uncertain.

#### 4.3.3 Is HIV/AIDS a problem in Botswana?

89% of the respondents reported knowing that HIV/AIDS is a major problem in Botswana while 11% stated that it is not a problem.

#### 4.3.4 Are more women infected by HIV/AIDS than men?

71.5% knew that more women were infected by HIV/AIDS than men, 23% believed the contrary with 6% not giving a response.



**4.4.1 Can insect/mosquito bites transmit HIV/AIDS?**

The majority (90.8%) of the respondents reported knowing it is not possible to get HIV/AIDS from mosquito/insect bites while about 9.2 % stated that it was possible, showing that there are still certain misconceptions in the target population on modes of transmission.

**4.4.2 Can sharing razors and needles transmit HIV/AIDS?**

The majority (91.5%) reportedly knew it is possible while about 8.5% stated that it was not possible, again this may allow for the few ignorant to share razors and sharp instruments resulting into HIV/AIDS infection.

**4.4.3 Can taking care of a sick person transmit HIV/AIDS?**

54.6% reported knowing that taking care of a sick person could not transmit HIV/AIDS, 42.3% stated that it was possible to get HIV/AIDS in this manner while only 3% did not respond.

**4.4.4 Can eating food cooked by an infected person pass HIV?**

The question if eating food cooked by an HIV infected person could lead to HIV, 97% reported knowing it is not possible while 2.3% stated that it was possible.

**4.4.5 Can sharing a toilet with an infected person pass HIV?**

99.2% of the respondents knew that sharing a toilet with an infected person cannot pass HIV while just less than 1% believed it could.

**4.4.6 Can HIV/AIDS be caused by witchcraft?**

99% of the respondents knew correctly that witchcraft cannot cause HIV/AIDS while about 1% stated that it was possible as is shown by the graph below.

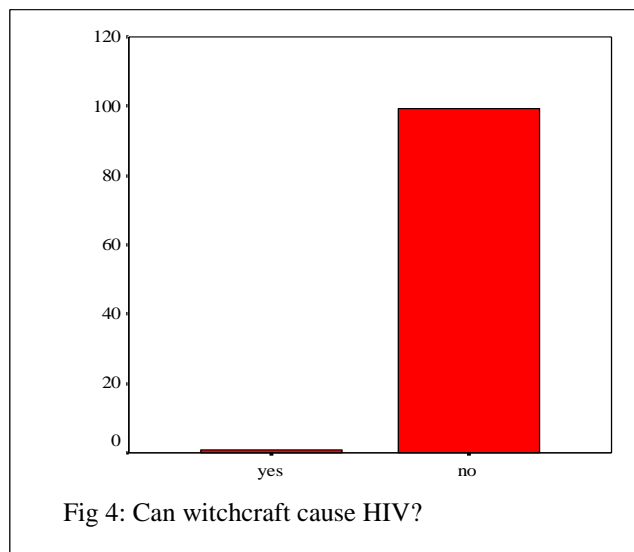


Fig 4: Can witchcraft cause HIV?

#### 4.5 Knowledge on avoidance of HIV/AIDS

To provide an insight into the respondents' knowledge on avoidance of HIV/AIDS, the following questions were asked:

- 1) Can HIV/AIDS be avoided by having sex with people you have known for a long time?
- 2) Can HIV/AIDS be avoided by bathing/washing thoroughly after sex?
- 3) Can HIV/AIDS be avoided by using condoms all the time?

The respondents showed a high knowledge level with a majority, who were able to answer the questions correctly as shown in table 4 below. A discussion of all questions follows.

Table 4: Knowledge on avoidance of HIV/AIDS

	HIV/AIDS can be avoided by having sex with only those you have known for long		HIV/AIDS can be avoided by bathing/washing thoroughly after sex		HIV/AIDS can be avoided by using condoms all the time	
	Count	%	Count	%	Count	%
yes	11	8.5%	2	1.5%	120	92.3%
no	118	90.8%	128	98.5%	10	7.7%
NR	1	.8%				

Total	130	100.0%	130	100.0%	130	100.0%
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#### **4.5.1 HIV can be avoided by having sex only with people you have known for a long time?**

The majority (91%) reported that this was wrong while 8.5% thought this could help people to avoid HIV infection with 1% being uncertain.

#### **4.5.2 Can HIV/AIDS be avoided by bathing/washing thoroughly after sex?**

The majority (98.5%) stated correctly that HIV/AIDS cannot be avoided by bathing/showering but 1.5% thought it could be avoided by bathing and showering thoroughly after sex.

#### **4.5.3 Can HIV/AIDS be avoided by using condoms all the time?**

92% reported knowing that HIV/AIDS can be avoided by using condoms at all times while about 8% thought it could not be.

#### **4.6 Knowledge of HIV/AIDS treatment**

The following questions were asked to determine the respondents' knowledge on the treatment of HIV/AIDS:

- 1) Can traditional doctors treat HIV/AIDS?
- 2) Is there treatment available for HIV/AIDS?
- 3) Is there a vaccine for HIV/AIDS?

As can be seen in the table 5 below, the respondents knowledge levels were generally low in question 2 and 3.

Table 5: Knowledge of HIV/AIDS treatment.

	Can traditional doctors treat HIV/AIDS?		Does HIV/AIDS have a treatment?		Is there a vaccine for HIV/AIDS?	
	Count	%	Count	%	Count	%
yes	5	3.8%	44	33.8 %	34	26.2%
no	125	96.2%	82	63.1 %	93	71.5%
NR			4	3.1%	3	2.3%
Total	130	100.0%	130	100.0%	130	100.0%

#### 4.6.1 Can traditional doctors treat HIV/AIDS?

The majority (96.2%) knew correctly that traditional doctors were not capable of treating HIV/AIDS but 3.8% thought they could treat HIV/AIDS.

#### 4.6.2 Does HIV/AIDS have any treatment?

On further inquiry if HIV/AIDS has any sort of treatment, 63.1% knew correctly that HIV/AIDS has no treatment while 33.8% thought HIV/AIDS could be treated. This was an absolutely startling revelation given the amount of information and education campaigns being rolled out.

#### 4.6.3 Is there a vaccine for HIV/AIDS?

Asked if there is a vaccine for HIV/AIDS, 71% knew correctly that there is no vaccine while 26.5% thought there is. Again there is a possibility of mis-information as the government regularly engages in numerous vaccination campaigns for example against H1N. This may be misunderstood to also mean there is also a vaccination for HIV/AIDS.

#### 4.7 Sexual behaviour and attitudes

The practices of sexual intercourse, its onset and frequency are important predictors of HIV exposure and risky behaviour. Given that sexual intercourse is the main transmission method for HIV in Botswana and thus in an effort to gauge the extent of sexual activity among the respondents were asked the following questions:



- 1) Have you ever had sex?
- 2) At what age was your first sexual encounter?
- 3) Are you currently sexually active?
- 4) Do you use condoms?

#### 4.7.1 Ever had sex?

Asked if they ever had sex, 78.5% of the respondents admitted having had sexual intercourse whereas only 20.8% responded they had never had sex and less than 1% did not give a response.

#### 4.7.2 Age at first sexual encounter

Respondents were then asked to indicate the age at which they had their first sexual encounter. The majority (57%) of the women had their first sexual encounter between 15-20 years, followed by 27% starting between the ages of 21-30, while 0.6% started at 10-15 and with 16% not responding as illustrated below in Fig 5.



These findings confirm the relatively early initiation into sexual activity. This coupled with multiple partners and inconsistent condom usage creates a major challenge in the fight against HIV/AIDS. There is need to design interventions that will focus on delaying sexual debut to a later time when they are able to make more independent decisions about their sexuality.

### 4.7.3 Current sexual activity

Respondents were asked whether they were currently sexually active and if such activity was restricted to one partner. 74% reported that their sexual activities were limited to one partner whereas 25% indicated multiple partners while less than 1% who did not give a response.

### 4.7.4 Condom use

With respect to condom use during sexual intercourse, 58% of the respondents indicated that they always use condoms while 30% used them sometimes, 3.8% never, and 7% did not respond. Given the fact that the efficacy of condom usage as a preventive measure depends on appropriate and consistent usage, the fact that about 41% of the respondents indicated inconsistent usage represents a major concern.

## 4.8 Decision making ability

To determine the respondents' abilities to participate in decision making in matters of sexual nature, the following questions were asked:

- 1) Have you ever had sex against your will?
- 2) Do you discuss sexual matters with your partner?
- 3) Would you tell anyone if you had HIV/AIDS?

Table 6: Decision making ability.

	Have you ever had sex against your will?		Do you discuss sexual matters with your partner?		Would you tell anyone if you had HIV/AIDS	
	Count	%	Count	%	Count	%
yes	82	63.1%	109	83.8%	104	80.0%
no	44	33.8%	17	13.1%	25	19.2%
NR	4	3.1%	4	3.1%	1	.8%
Total	130	100.0%	130	100.0%	130	100.0%

#### 4.8.1 Ever had sex against your will?

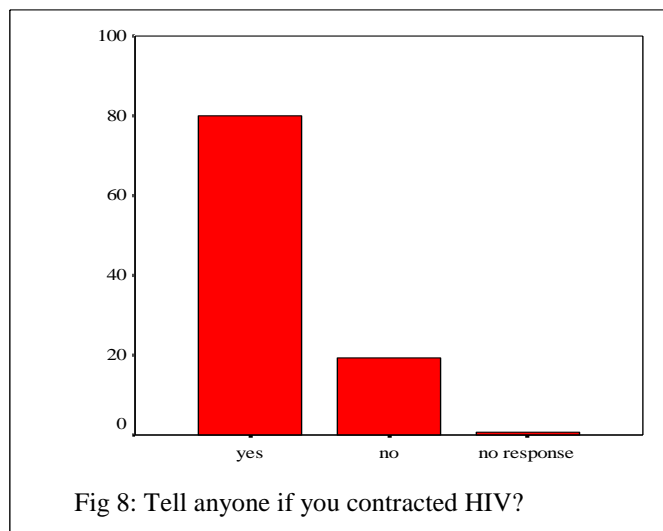
Asked if they ever had sex against their will, 63.1% reported they had been forced into sex against their will. This may be attributed to sexual coercion given the young age at which they initiate sex. 33.8% said they had not and just about 3.1% did not respond to the question.

#### 4.8.2 Ability to discuss sexual matters?

83.8% of the respondents reported they were capable of discussing sexual matters while 13.1% confessed not being able to discuss sexual matters with their partners while 3.1% did not respond.

#### 4.8.3 Would you tell anyone if you contracted HIV/AIDS?

When asked if they would tell anyone if they had HIV/AIDS, 80% indicated they would tell someone, whereas 19.2% reported they would not. This finding indicates that there is still some unwillingness for disclosure and this could be attributed to prejudice and stigma in the society.



#### 4.9 Attitudes towards those living with HIV/AIDS

To assess the respondent's attitudes towards those living with HIV/AIDS the following questions were asked:

- 1) Should people who knowingly spread HIV be charged?
- 2) Should HIV positive people be shut away to stop its spread?
- 3) Is the provision of ARVs a waste of money?
- 4) Do people with HIV/AIDS need help and support?

Table 7 below summarises the findings which indicate that although the majority of the respondents were generally sympathetic there remain a small proportion that demonstrates fear, ignorance and may perpetuate stigma in the community against people living with HIV/AIDS.

Table 7: Attitudes towards those living with HIV/AIDS.

	People who spread HIV knowingly should be charged		HIV positive people should be shut away to stop its spread		Provision of ARVs is a waste of money		People with HIV/AIDS need our help and support	
	Count	%	Count	%	Count	%	Count	%
yes	91	70.0%	14	10.8%	7	5.4%	122	93.8%
no	39	30.0%	115	88.5%	123	94.6%	8	6.2%
NR			1	.8%				
Total	130	100.0%	130	100.0%	130	100.0%	130	100.0%

#### 4.9.1 Should those who knowingly spread HIV/AIDS be charged?

When asked if people who spread HIV knowingly should be charged, 70% of the respondents thought it would be appropriate to charge them and only 30% did not think so. This brings to light the fact that there is still a lot of prejudice and stigma to HIV/AIDS in these communities hence the thought that justice should be done to those who knowingly spread it.

#### 4.9.2 Should HIV positive people be shut away to stop its spread?

88.5% of the respondents thought it would be inappropriate to shut HIV positive away but about 11% thought this would be helpful while just less than 1% were uncertain. This response clearly shows there are elements of stigma and prejudice towards HIV/AIDS infected with HIV/AIDS.

#### **4.9.3 Is provision of ARVs a waste of money?**

The majority (94.6%) thought it was money well spent, perhaps thinking that ARVs can cure AIDS while 5.4 % reported they thought that the money could be better spent

#### **4.9.4 Do people with HIV/AIDS need our help and support?**

The majority (93.8%) of the respondents felt that people with HIV/AIDS need our help and support while 6.2% thought they did not need our help and support.

### **5. Discussion, recommendations and constraints**

This study is seeking to assess the knowledge, attitude and practices to HIV/AIDS of women in Lobatse, Botswana. This study revealed that the overall knowledge and awareness of HIV/AIDS among the respondents was high but there are still gaps between knowledge and attitudes and beliefs, knowledge and sexual practices and attitudes and beliefs and sexual practices among the women in Lobatse.

This study revealed that there was high knowledge and awareness levels in the population as about 93% of the population had heard about HIV/AIDS, 86% reported that they knew someone who is HIV positive, 14% however did not know of anyone living with HIV/AIDS or were unsure. This is not surprising given the comparative stigma which surrounds the disease. These findings are similar to a study conducted by Coetzee (2002) when he determined the knowledge, attitudes, practices, and behaviour on HIV/AIDS in Ngami land, Botswana.

The majority of the respondents (83%) claimed substantial knowledge about HIV/AIDS and this was supported by about 85% correctly knowing the difference between HIV/AIDS with 89% knowing it was a major problem in Botswana. There is still a gap in the awareness though very minimal, but there is need for the more effective formulation and dissemination of programmes to cover these. Between 91-95% of the respondents were clear that a medium such as insect bites; drinking from the same glass, eating food cooked by a HIV positive person or using the same toilet did not constitute modes of transmission. Overall, the data revealed a high capacity

for distinguishing between myths and facts about transmission of HIV/AIDS through casual contact.

The majority of respondents reported that their main source of HIV/AIDS related information was mass media, which, however, may not be accessible in the more rural and remote areas. There is therefore a need to vary and streamline the sources of information by probably establishing programmes in schools/colleges and involving the health institutions wherever they are available to cement the knowledge bases and reinforce the existing modes of information dissemination.

The study further uncovered that there is a lot of misconception around the treatment of HIV/AIDS. Although the majority of the respondents were aware that there was no cure for AIDS and that no vaccine existed, quite a number (38%) considered that medical solutions existed to the problem of HIV/AIDS with 21% believing that there was a vaccine for HIV/AIDS similar to The Botswana Multiple Indicator Survey of 2000 in Gaborone and Selebi-Phikwe. This is a source of concern as it may influence risky sexual behaviour as the gravity of HIV/AIDS is clearly not well understood and there is a possibility that the 21% may be indulging in risky sexual behaviour, thus negating the efforts in the fight against HIV/AIDS.

Age at first sexual encounter is an important risk factor in HIV infection as initiation into sex at a young age often involves coercion. This is supported by the findings that 64% of the respondents had had sex against their will, a fact that increases the risk of trauma during intercourse with the potential of HIV transmission more magnified with inconsistent condom use. This study uncovered that the age at first sexual intercourse is relatively young, as 57% initiated sex between the ages of 15-20 and 27% had their first sexual intercourse between 20-30 years. This can be explained by the cultural and social norms in the community as sexual activity is commenced at a very early age.

This is a matter of concern as the younger females engage in sexual activities in contexts quite different to those of older women and are therefore unlikely to have the means and understanding to negotiate safe sexual practices. There is thus a need to start health education

including HIV/AIDS information much earlier from the homes and to the schools to lay a background for proper HIV prevention by inculcating safe sexual behaviour training from an early age. Further health education can be disseminated at social gatherings and even incorporated into religious ceremonies.

The findings also indicated that only 58% of the respondents consistently used condoms with the rest either sometime or never. Given the fact that the efficacy of condom usage as a preventive measure depends on appropriate and consistent usage, the fact that about 42% of the respondents indicated inconsistent usage represents a major concern. These findings are consistent with the findings from the NACA baseline research study on the knowledge, attitudes, behaviour and practices of young people in Gaborone in 1992, where despite high levels of knowledge and awareness there was low condom use.

Respondents reported tendencies gravitating towards discriminatory practices and attitudes against people infected with HIV/AIDS when about 11% want them shut away, 5% think provision of ARVs is a waste of money and 6.2% do not think they need help and support. This is similar to the findings by Tlou & Phaladze in their study in 2000. It leads to some people shying away from knowing their status and preferring not to tell anyone incase they knew. There is therefore a need for more educational interventions, to demystify the disease and curb the arising stigma. This will allow for more people to know their status and live more positively if they are HIV positive.

This study's major constraint was time. Data collection using questionnaires requires a lot of time in order to achieve a high response rate and several time consuming follow-ups had to be made to achieve this. Secondly, this study was limited to quantitative methods rather than both quantitative and qualitative, which could have provided a better understanding and deeper knowledge about the situation. Thirdly, because of the self administered nature of the questionnaire, the honesty of some responses may be questioned. However, the questionnaires were anonymous and participation was voluntary and confidential. Lastly, the results of this study should not be generalised to the whole population as only two of the residential areas in Lobatse were sampled.

## **6. Conclusion**

This study confirms just like in Abdool-Karim's study in Kwa Zulu-Natal in (2001) that in spite of the high levels of knowledge among women, the knowledge does not influence their adoption of safer sex practices. So whereas a lot of effort has been put into place by the government and other stakeholders into information and education campaigns, more urgent attention should now be directed towards translating the knowledge and information into the required behaviour change if we are to curb the HIV/AIDS epidemic.

These results further suggest that policies and efforts against HIV/AIDS should not be based on sexual behaviours and educational agendas only, but should be more gender sensitive - only then will it be possible to help women come out of their inhibitions so that they are able to discuss and seek information actively by integrating social issues such as gender inequality, gender empowerment through income generation avenues which will build their worth and empowering them to negotiate for safer sex with their partners.

It is also imperative that programme developers should study and understand the contexts, both culturally and socially within which risky behaviours occur in order to craft more effective behaviour change interventions because clearly the one size fits all interventions have failed to realise their aims.



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## Annexure

### Background information

1 How old are you?            15-20-----      21-30-----      31-40-----      40-49-----

Where do you live at the moment?

2 Boswelatlou\_\_\_\_\_ Peleng \_\_\_\_\_

3 What is your marital status?

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

4 What do you do for a living?

Student \_\_\_\_\_ Employed \_\_\_\_\_ Unemployed \_\_\_\_\_

5 What is your highest educational level?

Primary \_\_\_\_\_ Secondary \_\_\_\_\_ College/University \_\_\_\_\_

### HIV/AIDS Knowledge and Awareness.

6 Have you ever heard of HIV/AIDS?      Yes \_\_\_\_\_ No \_\_\_\_\_

7 How much do you think you know about HIV/AIDS?

A lot \_\_\_\_\_ enough \_\_\_\_\_ a little \_\_\_\_\_

8 From where do you get most of your information about HIV/AIDS?

Radio \_\_\_\_\_ T.V \_\_\_\_\_ Friends \_\_\_\_\_ Clinic \_\_\_\_\_

		<b>YES</b>	<b>NO</b>
9	Do you know anyone who is/was HIV positive?	_____	_____
10	Do you think there is difference between HIV and AIDS?	_____	_____
11	Do you think a person infected with HIV/AIDS has poor resistance against diseases and can become sick a lot easier?	_____	_____
12	Do you think HIV/AIDS is a major problem in Botswana?	_____	_____
13	Are more women in Botswana infected with HIV than men?	_____	_____
14	Can HIV be treated using Antiretroviral drugs (ARVS)?	_____	_____
	Can a person be infected with AIDS due to	<b>YES</b>	<b>NO</b>
15	Mosquito/insect bites	_____	_____
16	Sharing razor blades	_____	_____
17	Taking care of the sick	_____	_____
18	Eating food/ drink prepared by someone who is HIV positive	_____	_____
19	Using same toilet as someone who is HIV positive	_____	_____
20	witchcraft	_____	_____

Do you think HIV infection can be avoided by		YES	NO
21	Only having sex with people you have known for a long time	_____	_____
22	Washing thoroughly after sex	_____	_____
23	Using a condom every time you have sex	_____	_____
Do you think HIV/AIDS can be cured by		YES	NO
24	Traditional doctors'	_____	_____
25	AIDS has no treatment	_____	_____
26	Is there a vaccine for AIDS	_____	_____

### **Sexual attitude and behaviour**

27	You are sexually active? Yes _____ No _____		
28	How old were you when you first had sex? 10-15_____ 15-20_____ 21-30_____		
29	How many different partners have you had in the last three months? 1 _____ 2-5 _____ 6 and more _____		
30.	When you have sex, do you: Always use a condom ----- Sometimes use a condom ----- Never use a condom -----		
		<b>Yes</b>	<b>No</b>
31	Have you ever had sex against your will?	_____	_____
32	Can you discuss sexually matters with your partner?	_____	_____

### **Attitude towards HIV/AIDS and those affected by HIV/AIDS**

33	Do you know your HIV status?	_____	_____
34	If you had HIV/AIDS would you tell anyone?	_____	_____
35	Should a person who knowingly spreads HIV/AIDS be charged?	_____	_____
36	HIV positive people should be shut away to stop its spread.	_____	_____
37	Provision of ARV for HIV positive people is a waste of money	_____	_____
38	People with HIV/Aids are like any of us and need our help and support.	_____	_____

**END OF SURVEY**

**THANK YOU FOR YOUR COOPERATION**