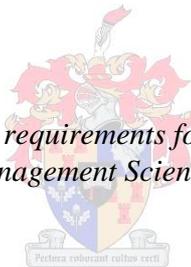


**THE RELATIONSHIP BETWEEN SOCIO-ECONOMIC STATUS AND  
THE PRACTICE OF HIV SELF-PROTECTIVE/PREVENTIVE  
BEHAVIOURS AMONG THE RESIDENTS OF MARUAPULA,  
GABORONE**

By

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*Assignment presented in fulfilment of the requirements for the degree of Master in Philosophy in  
the Faculty of Economic and Management Sciences at Stellenbosch University*



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March 2013

## **DECLARATION**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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## **ABSTRACT**

The incidence of HIV/AIDS in Botswana is one of the largest in the world taking its toll on many lives and posing developmental challenges to the nation. Nearly 25% of the population is living with HIV and 14% are newly infected; AIDS is acknowledged as the major cause of death. Most HIV and AIDS studies have been dominated by surveillance, biomedical and ethical methodologies. These approaches failed to stem the tide of HIV infection because they did not follow-up with the tracking of risky behaviours and the underlying causes of the behaviours. This research scrutinized socio-economic factors in relation to the spread of the epidemic. Available literature showed that little or no attention has been paid to the socio-economic backgrounds in which individuals exist in connection with understanding HIV and AIDS. This study used an economic model of risky sexual behaviour to explore the link between socio-economic status and the practice of HIV self-protective/preventive behaviours in Maruapula, Gaborone, Botswana. The research is vital as it goes beyond surveillance in an effort to establish why the community of the study is susceptible to HIV infection. This research used both collected data and that from BAIS II.

## **OPSOMMING**

Die navorsing is oor die verhouding tussen sosio-ekonomiese status en die praktyk van MIV self-protective/preventive gedrag binne Maruapula distrik. Die doel van die studie is om vas te stel of daar 'n verband tussen sosio-ekonomiese status en die praktyk van MIV-voorkomende gedrag onder die inwoners, van Maruapula, Gaborone, Botswana. Data is ingesamel deur die gebruik van vraelyste en die ontleding van die statistiek het getoon dat die is geen verwantskap tussen sosio-ekonomiese status en die praktyk van MIV self-protective/preventive gedrag onder die inwoners. Aanbevelings gebaseer op die bevindinge is gemaak met betrekking tot MIV-voorkoming in die woongebied in die besonder en in die land in die algemeen.

## **LIST OF ABBREVIATIONS AND ACRONYMS USED IN THE STUDY**

ACHAP	African Comprehensive HIV/AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
BAIS	Botswana AIDS Impact Survey
CSO	Central Statistical Office
HIV	Human Immunodeficiency Virus
NACA	National AIDS Coordinating Agency
SE	Socio-economic
SES	Socio-economic status
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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## DEDICATION

This project is dedicated to every life that was lost to HIV and AIDS, to people living with the virus and those whose unflagging support and care for them is unparalleled, to the political leaders who have shown great willpower and commitment in accosting the epidemic against all odds, to my children Tinetariro Victoria and Iris Shamiso who had to do with less attention while mother studied- I hope that by the time you marry and start families, AIDS will be a disease of the past, that your children will be born when this scourge is over.

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## **CHAPTER 1 INTRODUCTION**

### **1.1 INTRODUCTION**

This chapter comprises a background to the study, alongside the motivation, statement of the problem objectives, research method, limitations of the study, as well as the outline of thesis.

### **1.2 BACKGROUND OF THE STUDY**

According to the former US foreign minister Colin Powell, HIV/AIDS is today the largest threat to mankind – the greatest weapon of mass destruction (Redcross). At the global level it is the fourth largest cause of death (Gaffeo, 2003). HIV and AIDS are the biggest health problems in the world today, more so in sub-Saharan Africa and despite medical advancements; people continue to die because of them each year. Apart from killing people across all age ranges AIDS affects a wide spectrum of human existence. It kills in large numbers, spreads quickly, has profound social, economic and psychological impacts. As of 2010, UNAIDS estimated that 2.7 million people were newly infected with HIV globally. The rate of infection is highest in regions and countries where poverty is widespread, gender inequality is persistent and public services are weak. Almost 95% of people living with HIV live in developing countries, more so in Southern Africa. UNAIDS recorded in 2000 an estimated 33% of people in Botswana (which is the case study of this project) were living with HIV, and even now AIDS is the most common cause of death. The country became well known internationally for her excellent leadership; both politically and economically. Her response to the HIV epidemic was second to none in Southern Africa. In spite of all her achievements, people are still getting infected and many more are still dying, implying that there are currently many unresolved challenges that are impeding the successful implementation of HIV prevention programmes

At the UN General Assembly of June 2001, former President Festus Mogae lamented “we are threatened with extinction. People are dying in chillingly high numbers. It is a crisis of the first magnitude.” While other countries were left in a lingering state of shocked denial about the pervasive damage of the HIV/AIDS epidemic, Botswana responded timely and took the fight to the next best level. The Government instituted preventive and treatment programmes. These included public education and awareness campaigns, condom distribution, improvement of blood safety, prevention of mother-to-child transmission, routine HIV counselling and testing and provision of anti-retroviral drugs through the public health sector. The Government of Botswana in collaboration with NGOs has spent progressively billions of dollars in an effort to contain the HIV/AIDS epidemic. In spite of all these efforts and intervention programmes new infections continue to occur and people continue to die.

The Botswana AIDS Impact Survey II established that TB (63%) and STIs (31%) are the commonest reported health problems in Maruapula; health conditions are associated with HIV infection. STIs are risk factors in HIV infection for individuals of all ages. Death from AIDS is widely acknowledged. About 70% of respondents reported that AIDS is the leading cause of death in the community. It was found there is a high level of literacy in the community, 69% of the respondents were able to read in English or Setswana. This enables the community to understand written information about HIV/AIDS prevention.

A section of Maruapula is a community of poor people from different backgrounds. About 35% of the residents live in penury and near destitution. The living conditions of most of the residents are a testimony to this. Among the poor, there are instances of a family of four people sharing a room, using a communal pit latrine, shared with about 10 more people. Unemployment is rife in the location, so many men and women resort to small trading and vending. Mostly they sell airtime, sweets, chewing gum and anything that brings in an extra Pula (Botswana currency) while a few have makeshift barber shops. These vendors said they make an average of P700 a month and yet the rental of a room in the area is about P400. The cost of food is very high mainly because Botswana imports most of her foodstuff from neighbouring South Africa. There are also some foreigners who reside in this poor section of Maruapula and work in the suburbs and well-to-do neighbourhoods as gardeners and maids. Some go to strategic places every morning to solicit for what is commonly known 'piece jobs.' It is not uncommon for someone to go without a piece job for a whole week.

People in the area have always lamented lack of opportunities for further education, training and employment. The Botswana Education Policy stipulates if an individual fails to pass the junior certificate examinations, they cannot proceed with their education. This means they have either to stay at home or go to private schools. Most parents in Maruapula's poor section cannot afford private school education, private schools, commonly known as English Medium Schools charge fees of from about P5 000 upwards. A significant number of young men and women turn to drinking because of frustration and feelings of futility. There are men and women in different stages of drunkenness at any time of the day. Some join the Ipelegeng Programme (a Government poverty alleviation programme) where they slash grass along highways and sweep the roads. Ipelegeng workers earn a pittance that can hardly meet subsistence. Some people are even shy to join the programme because of its association with the underprivileged. It was also revealed that most women in the village start sexual activity in their teens. Most have sex with older men for material gains such as cell phones, clothes and money. Though they know about safe sex, some have unprotected sex because they are ashamed of collecting condoms from clinics and they cannot afford to buy them since a packet of three of the cheapest condoms cost about P10. There is also a claim the Government provided 'Lerato condoms' are not good enough. Some allege that they burst easily while some say they have too much

lubrication. This goes on to reflect that individuals in the community do not often control their own behaviours, but are controlled by the social, cultural, economic environment and the context in which the behaviours occur.

Even though there are many foreigners in Botswana, some brought in by the Government to address the skills shortage, some who come to seek a better life and some who come to trade. The Government of Botswana made a policy decision to exclude foreigners from its HIV/AIDS treatment and care programmes. “A policy decision was made that treatment programmes be available for citizens only,” (Dingake, 2005). Even if they can pay for ARVs, they cannot access it through the public health system. They have to for other diseases pay for consultation and drugs every time they visit a clinic or hospital. At a hospital the consultation fee is P50 when attended by a general practitioner and P80 to consult with a specialist doctor and at a clinic it’s P30 on each visit. The cost of drugs for individuals depends on the schedule prescribed. As a result most immigrants only go to the clinic when critically ill, for minor illnesses which are not really bothersome; they ignore them or buy remedies which do not need prescriptions. Some immigrants who knew their HIV status claimed they get their ARVs drugs from their countries of origin, but most pointed out most of times they run out of supplies and when they do not have money to go and collect their allocation, as a result they can go for months without taking medication. Still others claimed they bought ARVs from the black market. It can be deducted these so called ARVs from the black market may be counterfeit or of dubious origin or have questionable ingredients.

Citizens who cohabit with immigrants challenged the purpose of prevention efforts for them when their sexual partners will not get treatment.

A number of barriers are seen as hindering prevention efforts where the community comprises a large number of immigrants, about a third. These foreigners have no access to free condoms they have to buy them. In Botswana a packet of three condoms cost about ten pula from a pharmacy or a shop. People who are living on the verge of destitution, a condom become the least of their priorities. This economic barrier towards condom use affects many in the community being studied. Those who can access them, condoms require skills for use, the challenge of appropriate use or the skills of using the condom efficiently exists. It has been noted people in the community under consideration abuse alcohol, this results in impaired judgement and poor decision-making ability and failure to use condoms during sexual intercourse. Alcohol or drug use before or during sexual activity may result in having sex on the spur of the moment that may hinder condom use. Furthermore, condom use requires negotiation skills. In the case of transactional sex or sex work, it is sometimes difficult to insist on condoms because the buyer of sex dictates the terms.

Most participants' attitude toward HIV prevention was that while they see it as an important issue, as long as the community is determined by other pressing issues such as food insecurity, unemployment and poverty, AIDS prevention's importance fades from the lime-light. Poverty was sighted as one of the major driver to HIV/AIDS. Because of it young women engage in transactional and intergenerational sex. A young respondent observed, "Times have clearly changed; you don't sleep with someone because you love him, love certainly does not put food on the table or pay the bills, or buy clothes."

It is against this background that ways have to be found of engaging the whole community and working through individuals, families, the matriarchal system and supporting them in their own process of issue identification, prioritizing, action planning and mobilizing resources and using the whole person approach. The approach acknowledges that the individual faces a myriad of needs, each one which competes for his attention. The priority need may vary from day-to-day but will most probably be food, shelter, clothes and employment among many others than HIV prevention. Ways of supporting the whole person should include satisfaction for the immediate need while encouraging them to weave HIV/AIDS prevention.

### **1.3 MOTIVATION OF THE RESEARCH PROJECT**

This study is significant for several reasons it will provide an understanding of the relationships that exist between socio-economic status and the practice of safe sex. Secondly, the study will show the appropriateness of the prevention methods available for the residents of Maruapula. Some prevention strategies may be suited for a particular socio-economic group and not for the other. The study is anticipated to give a clear picture as to whether socio-economic status has a bearing in the practice of HIV self-protective/preventive behaviours. Through in-depth questioning the study hopes to uncover salient features of socio-economic status that matter in improving the practice of HIV self-protective/preventive behaviours. Thus the study will help in the understanding of factors that hamper the prevention methods that are available in the country. This study complements the efforts made so far to find effective strategies in containing the HIV/AIDS epidemic by using rigorous statistical techniques which have not been extensively used in previous studies. These are all in consonance with Botswana's Vision 2016 and United Nations Secretary General, Ban Ki-moon's 2010 call for global commitment to eliminate AIDS by 2020.

The spread of HIV infection in Botswana can be stopped when people react to the proposed interventions and they change their attitudes towards life. There are some countries in southern Africa (which is the worst affected region in the world) that have made great strides in allaying the spread.

These countries credit their success to effective prevention programmes (see for example UNAIDS Country Reports 2005: Uganda). Poverty and lack of opportunities have been cited as major contributors to the spread of HIV. This is because poverty has secondary effects such as selling sex, intergenerational sex, transactional sex and alcohol use. In sub-Saharan Africa today, high unemployment compels men to migrate to big cities to look for work, thereby disrupting family and social life. Moreover, traditional, social and sexual morality disintegrates as old traditions that produce unity and mutual help in communities are undermined or fade away. People who leave home to seek greener pastures in cities usually live in harsh conditions with limited or no access to health services. The prevalence of casual sex and sexually transmitted infections is likely to be high and the use of HIV-self protective behaviour is liable to be low. Alcohol abuse may be common in these environments - this lessens the thresholds of inhibition and compromises rational decision-making. Effective prevention programmes, which should include the practice of 'HIV self- protective/ preventive behaviours', have to consider addressing problems of unemployment, lack of higher education and chronic poverty. HIV prevention services have to be designed to meet realities of people's everyday lives, incorporating cultural, social and economic factors. A holistic approach to the prevention of the spread of HIV is required, an approach such as one that addresses several factors of the determinants of the spread of HIV. The African HIV/AIDS epidemic is probably predominantly sexually acquired, meaning that curtailing it require methods that address people's vulnerability, namely, the underlying determinants of the spread of the malady. There is need for a more comprehensive range of preventive methods that cater for all people regardless of who they are or their socio-economic status. Poor people need to be empowered to shape a better standard of life by alleviating their poverty, food insecurity and ailments.

#### **1.4 PROBLEM STATEMENT**

For the purpose of the study, the following research question was formulated:

Does socio-economic status influence the practice HIV-self protective/ preventive behaviours among residents of Maruapula?

- HIV self-protective/preventive behaviours encompass:
- Negotiating the use of condoms
- Discussing sexual history with potential sex partners
- Refusing sexual intercourse without condoms
- Having an HIV test and discussing about HIV test with potential sex partners
- Abstaining from alcohol and drug use before or during sex
- Having only one sex partner

## 1.5 OBJECTIVES OF THE STUDY

- To determine the residents' knowledge of HIV self-protective/preventive behaviours.
- To assess underlying attitudes towards the practice of HIV self-protective/preventive behaviours.
- Identify gaps between residents' knowledge and the practice of HIV self-protective/preventive behaviour.
- To assess the effectiveness of the response to the HIV epidemic.
- To assist in designing prevention services that is suited to the needs of the residents

## 1.6 RESEARCH METHODOLOGY

The research will apply both quantitative and qualitative methodologies. Quantitative methods will be employed in order to investigate the relationship between socio-economic status and the practice of HIV self-protective/preventive behaviours. This will enable the researcher to identify if there is any association between socio-economic status and practicing of self-protective/preventive behaviours. Apart from data which will be collected specifically for this project, raw data from BAIS II (Botswana Aids Impact Survey) will be sought and subjected to similar statistical analyses in order to provide solid evidence regarding the relationship between socio-economic status and the practice of HIV self-protective/preventive behaviours. Responses from people of different socio-economic statuses will be studied to investigate how socio-economic factors affect individuals' perception of vulnerability to HIV infection.

The study will be carried out in Maruapula residential area in Gaborone, Botswana. The residence is about 3km from the city's main mall. The houses in the residential area comprise of what is known as high cost (mansions), middle cost, (standard three bed roomed houses), low cost (2-3 bed roomed houses) and compound like houses, some with no plan.

A random sample of 30 people will be selected to participate in the study. This sample is deemed to be representative in that all sections of social economic status are represented. The random sample is important because the intention is to generalize directly to a population based on a single research study results. A sampling frame will be stratified by giving the elements in each set identification numbers, then drawing a random sample from each of the groups, (rich, and poor). The sets of randomly selected respondents (rich, poor) will be combined to have the final sample. The sample from each category will reflect the relationship between socio-economic status and the practice of safe

sex in the categories. The technique by which the sample was chosen is vital to the discussion and the validity of the research findings. Eligible men and women have to be 18 years and older, normally resident in Maruapula and mentally competent to complete the questionnaire.

Two structured questionnaires, one of the summated rating scale containing two or more items will be used to elicit responses from the subjects chosen in the study. The second questionnaire, of the Likert scale, containing 25 questions will be used to elicit information about a) the residents' knowledge of HIV self-protective/preventive behaviours. b) To assess the underlying attitudes towards the practice of HIV self-protective/preventive behaviours. c) To identify gaps between the residents' knowledge and available support services. The questionnaire was identified as the most appropriate instrument of gathering easily quantifiable, specific data for a holistic understanding of the problems associated with developing HIV prevention interventions for the residents. The questionnaire is readily available and the information is collected firsthand. The chances of misinterpretations and misreading of questions and responses by both the researcher and respondents are limited. The questionnaire addresses pertinent questions about socio-demographic characteristics, including age, gender, marital status, educational level and employment status. There are 25 questions in the questionnaire. The questions are specifically selected to yield answers required for the study. In the questionnaire, the items do not have correct answers and some items are worded positively while others are worded negatively. This questionnaire is also designed to assess underlying constructs that are quantifiable. Care was taken to ensure the questions are not leading, biased or ambiguous, double barreled, thus the questions are comprehensive and easy to understand. The questionnaire will be presented in English and translated into the local language for those that will prefer to respond in the local language to ensure there is understanding of what is expected from the respondents.

## **1.7 OUTLINE OF CHAPTERS**

The research is an exploratory/descriptive study examining how people protect themselves or prevent themselves from HIV infection. It also investigates the socio-economic status of the Respondents and whether this has a bearing on the practice of HIV self-protective/ preventative behaviours.

**Chapter 1:** In this chapter, a background to the HIV epidemic and the motivation of the study is clarified. In addition, the statement of the problem, objectives of the study and a brief outline of the approach used, sample size, the instrument and descriptive statistics is shown.

**Chapter 2:** This chapter will explore and analyze relevant literature pertaining to what HIV/AIDS is, how it affects people, the incidence and extent of the epidemic globally, in the sub-Saharan region and in Botswana is illustrated

**Chapter 3:** The chapter gives an account of the problem statement, objectives of the study and a detailed research approach which spells out the advantages and the disadvantages of the selected approach. Furthermore, an explanation on the sampling procedure is expounded.

**Chapter 4:** Findings from the completed questionnaires are presented and analyzed. The information or data is illustrated in the form of tables, graphs, pie charts including percentages and frequencies.

**Chapter 5:** Conclusions are drawn from the analyzed data with reference to the study objectives. Recommendations are also made based on the problem that was stated at the beginning. Suggestions on how to overcome the limitations that were cited earlier are given.

## **1.8 LIMITATIONS OF THE STUDY**

It was difficult to get a representative sample because at some suburban houses the owners would accept to participate but it was later established the questionnaire was completed by either their gardener or house maid. This was evident because one could tell the house is a four or more bed-roomed and yet the responses indicated the responded lived in a one-roomed house and earned between P500-1000. There was also an indication people in the area have developed what will be termed 'research fatigue' and skepticism about researches, apparently because they do not bring any change to their lives. Instead of selecting the participants as originally intended, use had to be made of those that were willing to participate. When people are struggling to survive they want to be aided not investigated.

## **1.9 CONCLUSION**

This chapter summarized the general direction of the study. The introduction and background of the study have been clearly described. The problem statement, the purpose and objectives of this study have also been explained including the research question which was stated, and operational definitions were presented so that clear demarcations are set for the study. In the chapter dealing with the literature survey, a more in-depth discussion of the literature pertaining to HIV/AIDS, its incidence globally, regionally and nationally follows. Furthermore, the efforts that have been taken to accost the epidemic will be discussed in more detail. An overview of socio-economic status and how it impacts the spread of HIV is going to be given.

## CHAPTER 2

### LITERATURE SURVEY

#### 2.1 INTRODUCTION

In this chapter, the meaning of HIV and AIDS will be explained, with emphasis on how the virus is contracted. How the virus destroys the immune system and makes the victim vulnerable to other infections will be elucidate.

##### 2.1.1 OVERVIEW- WHAT IS HIV AND AIDS?

The acronyms HIV and AIDS stand for human immunodeficiency virus and acquired immune deficiency syndrome respectively. HIV enters the body through infected body fluids which attack the infected person's lymphocyte cells causing pervasive immunocompromisation.

The HIV virus is a retrovirus and has the ability to convert RNA to DNA by the way of an enzyme - reverse transcriptase. The virus cell consists of a lipid bilayer envelope with the cell surface receptors formed from glycoprotein. The core of the virus consists of a glycoprotein shell (capsid) with the viral nucleic acid and molecules of reverse transcriptase enzyme. The cell surface antigens for the HIV virus connect only with certain types of host cell, these are (HIV and AIDS, a strategy for nursing care. p.18);

- CD4++ Lymphocytes (T helper cells),
- CD4+ Reticulo-endothelial dendritic cells,
- related Langerhans cells in the skin and,
- Mucous membranes.

The surface receptors of the virus fit exactly with those of the CD4+ cells using a system alike that of a lock and key. After that a series of phases take place before seroconversion occurs. The virus cell can be encompassed into the host cell through the process of endocytosis. As soon as it is in the cell, the viral capsid splits and the viral RNA is released into the host cell along with reverse transcriptase. This enzyme facilitates the conversion of RNA to DNA. The newly copied out DNA is then introduced into the host cell nucleus and is integrated into the host DNA. In this way, the host cell becomes permanently infected with the HIV virus. A period of latency then comes after, where the body appears and functions normally and the disease stays dormant. The infected cell in the latent stage is called a provirus. Even though not replicating, it has the potential to replicate causing serious infection. The viral cell reproduces by budding in the cell; the produced RNA is enclosed by a protein

coat. Moving towards the cell membrane it is surrounded by a glycoprotein covering and receptors. It breaks away (buds) - from the main cell to produce new virions or progeny HIV. "The replication cycle is very efficient, only 1 out of 100 new virions are not functional and infective," Pratt, 1995.p.21). The progeny HIV particles can then move to bind with other CD4+ lymphocytes and the whole cycle is repeated. Original host cells may become broken down due to the new progeny breaking away and damaging the cell membrane. Cell death is unavoidable in these circumstances. The very first symptoms following this seroconversion occur about four weeks following infection. Flu like signs - fever, tiredness, throat infections, increases in gland size and joint pain manifest. These symptoms usually go unreported or pass by as an influenza type illness. This period of the first illness type symptoms is called acute primary infection. The virus continues to replicate within the host body, but HIV may not be determined until further clinical tests are performed or further symptoms and signs present. The blood tests to determine the HIV virus cannot determine this stage of the disease. The test, if carried out before seroconversion, can give an untrue negative reading and therefore has to be done again at intervals of three months. The ELISA technique is the usual method used. "The enzyme linked immunoabsorbent assay is a method of measuring the amount of a substance in the body. An enzyme that will link to the substance is produced; the amount of an easily measured enzyme that then binds to the antibody complex enables accurate measurement" (Oxford Colour Medical Dictionary).

### **2.1.2 HOW HIV IS SPREAD**

HIV is spread by the following methods:

- ❖ Heterosexual and homosexual intercourse with an infected partner.
- ❖ Parenterally through infected needles
- ❖ Materno-foetal routes (mother to child including via breast milk).
- ❖ Infected blood and blood/ body products.
- ❖ Nosocomial infection.

HIV has been identified in various body fluids, but it is highly concentrated in blood, semen and vaginal fluids (van Dyk 2008). When an infected person has penetrative vaginal or anal sexual intercourse with an uninfected person, without using a condom, there is a high probability of infection. When HIV enters the body it weakens the body's immune system, rendering the infected person vulnerable to infections. Because HIV prevents the immune system from functioning properly, a person who is infected becomes highly susceptible to other pathogens. The immune deficiency leads to exposure of the infected individual to a gamut of infections which in ordinary circumstances are not incurable. When a person is infected the HIV fights the cells of the immune system which are critical

for immune reaction. Since the immune system is disabled by the HIV; other infections can no longer be fought. People who are HIV positive are most infectious in the early stages of infection, which is within the first four to eight weeks and during the last phase of AIDS when they are very ill. This is because the viral load at these two stages is at the peak, (International AIDS conference, 2002). HIV affects the human immune system by using enzymes called the reverse transcriptase, protease and integrase. The HIV connects itself to the CD4 receptors known as macrophages and CD4 cells. The vaginal and anal tracts have the receptors that the HIV connects to easily. There are also several mucous membranes in the male and female genitalia called Langerhans cells. According to Evian (2000), "Langerhans cells are antigens presenting cells, which mean they present foreign antigens to the immune system." These Langerhans cells allow transmission through an intact mucous membrane. It is also possible for HIV to go directly into bloodstream during sex. Friction during penetration may cause unrecognizable tears that will increase the chances of infection. HIV infection is compounded by STIs such gonorrhoea, syphilis, chancroid, genital herpes and Chlamydia. Untreated STIs in either partner increases the risk of HIV transmission during unprotected intercourse tenfold (World Health Organization 2000a). Females have higher risk of being infected by HIV because they receive semen during intercourse and they retain it longer in their bodies. They are more likely to be infected just before, during or soon after menstruation. The reason for this is because the inner uterus lining is raw and exposed.

### **2.1.3 HIV/AIDS PREVENTION METHODS**

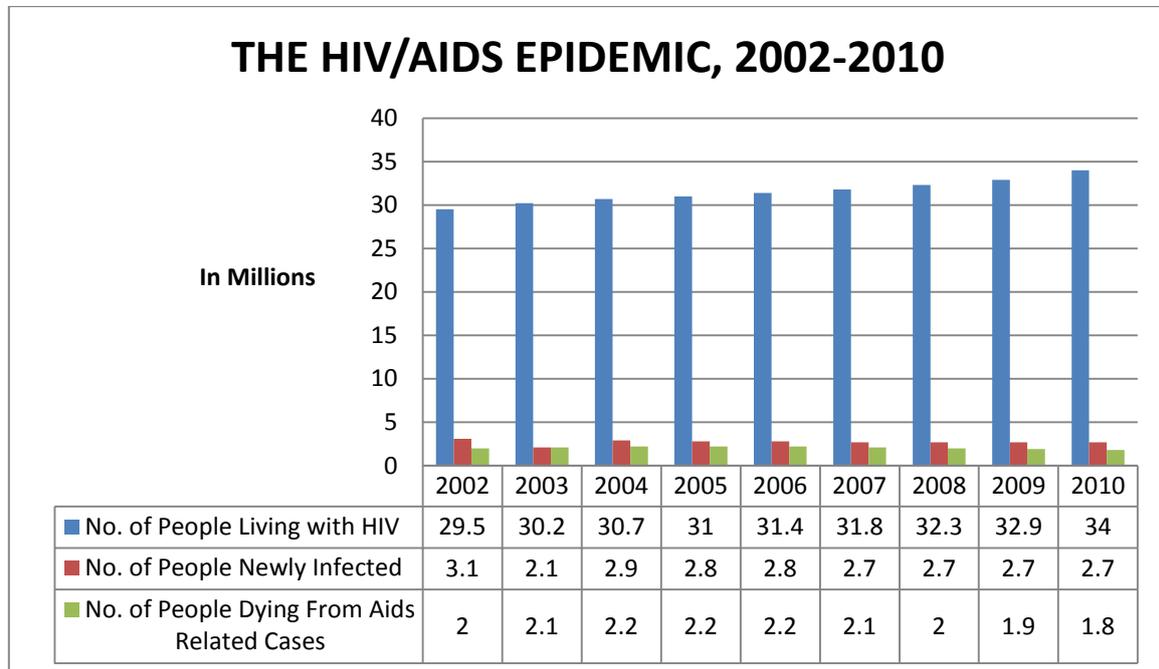
HIV is different from other epidemics that have plagued sub-Saharan Africa in that it is terminal and that it is mainly sexually transmitted. Initially, most countries tried to stop the spread of infection by using, informing the populace about the epidemic and trying to convince people to change their sexual behaviour. Behaviour change which encompassed the ABC of HIV/AIDS was deemed to be effective. This was because Uganda, a country that was heavily burdened by HIV and AIDS had succeeded in reducing infection rates from 15% in the 1990s to 6.5% in 2004 (Linsay 2001). UNAIDS (2004) underscores that, "condoms are critical elements in comprehensive, effective and sustainable approaches to HIV prevention and their promotion must be accelerated." It is therefore essential to improve knowledge and effectiveness of condom use in the face of limited options. A number of prevention programmes are currently running in many sub-Saharan African countries, these include; public education and awareness, condom distribution and education, improvement of drug safety, prevention of mother-to-child transmission (PMTCT), male circumcision, and targeting high risk adult populations. Most of these programmes seem to be missing the mark because there are still significant numbers of new infections daily. Even with the so called 'universal treatment access', several countries are still fighting to contain the epidemic. Referring to Botswana, HIV&AIDS in

Botswana (2010) commented, “If it is ever to defeat the epidemic, Botswana must find a way to halt the spread of HIV.” There are many factors both at micro and macro levels that enhance vulnerability. Such factors as poverty, gender violence and inequitable distribution of resources, economic instability, unemployment, harmful cultural and social practices, and lack of opportunities need to be accosted in efforts to curb HIV and AIDS.

Initial strategies in the response to HIV and AIDS failed to stem the tide; hence the focus should shift from one off awareness campaigns and condom distribution, neither of which address related problems such as barriers to condom use and behaviour change related to socio-economic issues. While it is plausible to spend much effort and resources on caring for those infected and affected, considerable resources and effort have to be spent also on preventing infection. The reasoning being, man have only today to save someone’s life and the next ten or more years to plan for their care. The most effective strategy in prevention is HIV counselling and testing (HCT) because it encourages behaviour change. People who know their HIV status are more likely to protect themselves and others from infection. Behaviour change is a real challenge in the face of other survival issues that afflict a majority of adults, which is why there is a need to start with young people who have to be trained to avoid harmful behaviour from the onset. Information/education received is likely to be understood and taken seriously at an early age, hence “you cannot teach an old dogs new tricks” bad habits are formed earlier in life and so are good habits.

### **2.2.1 THE INCIDENCE AND INTENSITY OF HIV AND AIDS IN WORLD**

The overall increase of the global AIDS epidemic seems to have stabilized. The number of new infections have been gradually declining yearly ever since the late 1990s and there are less AIDS related deaths. This is due to the momentous scale up of anti-retroviral therapy (ART). Even though the number of new infections has reduced, levels of new infections on the whole are still elevated and with considerable decline in mortality, the number of people living with HIV (PLHIV) worldwide has increased, (UNAIDS 2011). Figure 2.1 shows the incidence of the HIV epidemic from 2002-2010.

**Figure 2.1****The HIV/AIDS Epidemic, 2002-2010**

Source: **UNAIDS Progress Report 2011**

In 33 countries in sub-Saharan Africa the HIV/AIDS numbers have lessened by about 25% between 2001 and 2009, whereas in Central, Eastern, Western Europe, Central Asia and North America the prevalence of new infections stabilized for the last five years. While in sub-Saharan Africa infection is spread mainly by heterosexual intercourse, in these countries infection occurs mainly among men who have sex with men and injecting drug users. In South Africa, Zimbabwe, Zambia, Botswana and Tanzania, the biggest drop in HIV/AIDS incidence is among the youth, also, AIDS related deaths among children reduced by 19% from 2004-2009 worldwide. Infection rates are highest among poor countries, with sub-Saharan Africa home to over 60% of cases. Table 2.1 gives a picture of the current HIV/AIDS statistics worldwide. Of these statistics, sub-Saharan Africa accounts for 67% of people living with HIV, 70% new infections and 70% deaths (UNAIDS 2011). This should be worrying considering that Africa makes up just 12% of the world population.

**Table 2.1**  
**The global HIV/AIDS Epidemic**

	Adults and children living with HIV	Adults and children newly infected with HIV	Prevalence of HIV infection among adults (%)	Adults and children dying from AIDS-related causes	Prevalence of HIV infection Among people 15–24 years old (%)	
					Men	Women
<b>Sub-Saharan Africa</b>						
<b>2010</b>	22 900 000	1 900 000	5.0	1 200 000	1.4	3.3
<b>2001</b>	20 500 000	2 200 000	5.9	1 400 000	2.0	5.2
<b>Middle East and North Africa</b>						
<b>2010</b>	470 000	59 000	0.2	35 000	0.1	0.2
<b>2001</b>	320 000	43 000	0.2	22 000	0.1	0.1
<b>South and South-East Asia</b>						
<b>2010</b>	4 000 000	270 000	0.3	250 000	0.1	0.1
<b>2001</b>	3 800 000	380 000	0.3	230 000	0.2	0.2
<b>East Asia</b>						
<b>2010</b>	790 000	88 000	0.1	56 000	<0.1	<0.1
<b>2001</b>	380 000	74 000	0.1	24 000	<0.1	<0.1
<b>Oceania</b>						
<b>2010</b>	54 000	3300	0.3	1600	0.1	0.2
<b>2001</b>	41 000	4000	0.2	1800	0.1	0.2
<b>Latin America</b>						

<b>2010</b>	1 500 000	100 000	0.4	67 000	0.2	0.2
<b>2001</b>	1 300 000	99 000	0.4	83 000	0.2	0.1
<b>Caribbean</b>						
<b>2010</b>	200 000	12 000	0.9	9 000	0.2	0.5
<b>2001</b>	210 000	19 000	1.0	1800	0.4	0.8
<b>Eastern Europe and Central Asia</b>						
<b>2010</b>	1 500 000	160 000	0.9	90 000	0.6	0.5
<b>2001</b>	410 000	210 000	0.3	7 800	0.3	0.2
<b>Western and Central Europe</b>						
<b>2010</b>	840 000	30 000	0.2	9 900	0.1	0.1
<b>2001</b>	630 000	30 000	0.2	10 000	0.1	0.1
<b>North America</b>						
<b>2010</b>	1 300 000	58 000	0.6	20 000	0.3	0.2
<b>2001</b>	980 000	49 000	0.5	19 000	0.3	0.2

**Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2011 Report on the Global AIDS Epidemic.**

These statistics confirm the findings by researchers regions, countries and groups that are already in disadvantage economically, politically and socially are often most vulnerable to HIV/AIDS.

The incidents of HIV infection declined by 19% between 1999 and 2009 globally, (UNAIDS 2010). There was a fast-track of the provision of anti-retroviral therapy (ART) in low and middle income countries which surged thirteen-fold from 400 000 in 2003 to 6.65 million by the end of 2010. This accounts for 35% of those in need, allowing individuals to live longer and productive lives. In spite of the fact that ART is not a cure, it has changed HIV and AIDS from a life threatening illness to a manageable chronic disease. Although infection rates decreased significantly from their peak in 1999, new infections continue overtake the number of people on treatment. As a result most people in need of ART have no access to it and the demand keeps on growing. Perusing the data reveal changes in

the trend of HIV incidence which may seem favourable to the response, but the longevity of HIV infected people implies the need for long term health and social care; come in the form of ART and subsistence grants.

### **2.2.2 HIV AND AIDS IN BOTSWANA**

Botswana became independent on 30 September 1966 and was among the 25 poorest and least developed countries in the world at the time. At independence Botswana's material and social infrastructure had not yet developed, resulting in soaring levels of poverty and illiteracy (Vision 2016:14). This state of affairs has changed radically in the past three decades and today Botswana has been classified by international financial institutions, such as the World Bank, as a middle income country. Botswana has been a consistent net contributor to the World Bank over the last decade; in 1999, for example, US \$14 million in net transfers was made (Taylor, 2001:6).

The first case of AIDS was announced in 1985. During its peak between 1995 and 2009 Botswana's HIV/AIDS epidemic reached worrying proportions. By the end of 2009 the number of people living with HIV had soared to 300 000 adults, a figure widely regarded as incredible as far as epidemics are concerned. In the same year the estimated adult prevalence was 24.8 percent among the 15-49 age range, making the country second highest in AIDS after Swaziland. Life expectancy fell remarkably from 65 years between 1990 and 1995 to less than 40 years between 2000 and 2005, a variation of 28 years. The fast spread of the virus posed the greatest hazard to the socio-economic development of Botswana, in those years the HIV/AIDS epidemic had become a catastrophe, constituting a national emergency. The then President of the Republic, Festus Mogae did not mince his words when he called it "-----a crisis of magnitude" (CCA p. 43). According to CCA (p. 44) " -----nearly everyone in Botswana was living with HIV/AIDS-an infected person, or someone trying to cope with the sickness-or loss of a relative, a colleague at work, a friend or a loved one."

Many researchers have tried to establish why HIV in Botswana spread at such an alarming rate (see, for example, Stegling, 2000). The findings pointed to the demographic, social, economic and political traditionally and where their parents and grandparents live. Apart from these two homes, some have cattle posts where livestock is raised and some farm agriculture. A majority of the people visit these homes frequently. Suppose an individual is infected, there is a probability of them infecting sexual partners in these places; infection is likely to occur at both ends of the move. It was also established people in Botswana delay before they decide to get married. It is common to find a forty year old man who is not married. This is because of the stringent conditions of marriage. A man is supposed to pay the full lobola or bride price and have a white wedding before they can be considered legally married. As a result there is more cohabitation before a man settles, he might have lived with many women

(Zaffiro, 1994:84). Another significant finding as the high rate of infection was poverty and income disparity in Botswana. As of 1993, 47% of the population was considered as living below the poverty datum line, with about a third of the population living in dire poverty, the situation has since changed with an estimation of 36.7% below the poverty line in 2002, this is still high and renders more than a third of Botswana's population being poor (Government of Botswana & UNDP, 2004:21).

### 2.2.3 THE SPREAD OF HIV AND AIDS IN BOTSWANA

Like in most sub-Saharan African countries the main determinant of HIV transmission in Botswana is unprotected heterosexual intercourse and mother-to-child. However, from time immemorial ravaging outbreaks such as bubonic plague, Black Death and cholera generally affected specific socio-economic backgrounds that provided abundant conditions for the transmission of the diseases. The conditions which are called 'underlying determinants,' include poverty, social disorder and chaos, as in the situation of war, prostitution, child labour, homelessness and social and cultural transition. Nowadays and in the case of HIV/AIDS there are other determinants which are a result of the nature of the disease. These are intergenerational sex, gender inequality, cultural practices and norms, stigma and denial, population mobility and urbanisation. Researchers have established poverty lead girls and women to engage in transactional and intergenerational sex or even prostitution. Severe poverty may force females to exchange their bodies for money, food, shelter and other material goods.

## 2.3 HIV/AIDS, SOCIO-ECONOMIC STATUS AND THE PRACTICE OF HIV SELF-PROTECTIVE/PREVENTIVE BEHAVIOURS (table 2.2)

Table 2.2

### Socio-economic Status

Individual socio-economic status description	High	Medium	Low
	Completed high school/tertiary education, employed in skilled or managerial position	High school education, semi-skilled or unskilled job and earning an reasonable salary	No schooling or primary education, no formal employment, gets a pittance from whatever occupation.

Source: Gender Links 2011

In U.S.A level of education and income are mostly the generally used indicators of socio-economic status (Issue Brief 5: 2009). These two are deemed to be strongly related to a number of tests of wellbeing and health-related behaviours in life. An individual's education and income as well as other associated attributes including, occupation, accrued riches or wealth and community socio-economic conditions have the potential of influencing health in countless ways. The apparent and undisputable results of severe and chronic poverty include inadequate housing which may result in exposure to infectious diseases and mental health issues such as stress. These are a consequent of the continuous strive to meet basic survival with a constrained income. As with HIV infection, while socio-economic status can determine the risk, there are other factors in the community that can make people vulnerable, for example, the location of the community and the socio-cultural practice and beliefs. Perry (1998) attests "HIV is a disease that is embedded in social and economic inequity as it affects those of lower socio-economic status at a disproportionately high rate." This is because lack of resources necessary for subsistence is likely to lead to risky activities linked to contraction of HIV. The behaviours include earlier initiation to sexual activity and less frequent use of condoms, (Adler, 2006). As with women low economic position and the experience of chronic poverty and futility may lead to carefree and riskier sexual encounters. Capricious housing and squalor have been associated with infectious diseases in general and STIs and HIV and AIDS in particular. In the U.S.A "unstable housing has been linked to risk of HIV infection, including intravenous drug use and unsafe sexual behaviours" (Aidala, Cross, Stall, Harre and Sumartdjo, 2005).

Poverty more so continual makes people, especially women and girls from deprived homes vulnerable to the HIV through engagement in risky behaviours such as transactional sex, intergenerational sex and sex for money. Gillespie et al (2008) established that, "poverty and food insecurity are thought to increase sexual risk taking, particularly among women who may engage in transactional sex to procure food for themselves and their children." Most women of low socio-economic status may find it difficult to be assertive in relation to condom use with sexual partners. This is because of their reliance on their partners for subsistence (Gillespie et al op cit). Never-ending poverty is prone to cause food insecurity which in turn may cause malnourishment which may also lead to compromised immunity. A weakened immunity system easily succumbs to infections including HIV.

Affluent people may find it a matter of choice whether to engage in self-protective/preventive or risky behaviour. But when life is a constant struggle to meet bare subsistence, other things may not matter in the face of limited options. Besides "low social and economic positions put young women at a disadvantage in sexual negotiations because they are more dependent on their partners for survival" (Hallman, 2004, p.22). This can cause individuals living in penury and near destitution dismiss

HIV/AIDS as another one of the challenges the must encounter in striving to survive (van Niekerk 2008).

Dixon (2002) observed “where there is poverty AIDS seems to follow close behind.” Many authorities agree with the statement and there is adequate evidence in the socio setting of individuals. The implication therefore is fighting AIDS without addressing the issue of poverty becomes futile. Unemployment problems and low wages which result in poverty need urgent attention in Botswana. As long as there are lack of employment opportunities, sex for cash and other commodities will be seen as a rational response to poverty. If money became available, they may be no need to engage in potentially risky behaviour and risky sexual activities. Botswana’s Vision 2016 suggests, “For as long as part of the population is extremely rich and another part extremely poor, HIV/AIDS will continue to plague the nation.” The determination and success to end poverty and curb HIV infection is thus tied with undertaking to create additional opportunities for employment and income generation, more especially among the youth and poor women. Tackling such social ills as poverty, illiteracy, violence against women, inequitable distribution of wealth and hunger becomes imperative.

#### **2.4 BOTSWANA’S RESPONSE TO THE HIV/AIDS EPIDEMIC**

Since the 1990s, no aspect of Botswana’s existence escaped the adverse effects of HIV and AIDS. It had also become obvious that eradication of the malady was not likely to occur soon, and that without resolute efforts, the country was going to lose about a third of its population in less than a decade. Former Presidents Sir Ketumile Masire and Festus Mogae tasked the cabinet with leading the HIV/AIDS campaign at every turn. Even now, the government continue to demonstrate its unflagging commitment to stamp out the epidemic. In his address to the nation in 2012, President Ian Khama remarked, “through the proactive leadership of my immediate predecessor, Former President Festus Mogae, we recognised that we could not afford to ignore the scourge of HIV/AIDS in the blind hope that it would somehow leave us in peace.” Because of committed, visionary leadership and the acceptance that HIV and AIDS was a threat to the lives of Batswana, the government saved numerous lives. According to the president, “we can take comfort in the fact that through vigorous outreach efforts, today over 110,000 people are now on ARVs, while we have reduced mother-to-child transmission of the virus from infected females from about 40% to 4%.”

The HIV and AIDS related deaths became particularly voluminous in the 2000s. In 2009 there were an estimated 300 000 adults living with HIV in Botswana (UNAIDS, 2010); translates to a quarter of the population aged 15 and above. Since Botswana’s population is less than two million, this is quite

alarming. In response, the government embarked on audacious HIV and AIDS campaigns in pursuant to the national commitment to lessen the spread of infection, (see also Gender Links 2011).

The Government of Botswana fired from all cylinders in an effort to contain the epidemic, it headed Kofi Annan's (former UN Secretary –General) announcement “there is no more time for half-measures----- AIDS is an unparallel nightmare”. The initial response which was from 1987-1989 consisted of screening blood to eliminate the risk of HIV transmission through blood transfusion. From 1989 to 1997 there was the introduction of information, education and communication programmes. Information and education provided hinged on the ‘ABC’ of AIDS. This means: Abstain, be faithful and Condomise if you cannot do the other two. Figure 2.2 is a roadside sign found on major highways in Botswana. BAIS II ascertained about three quarters of Botswana's population is literate in light of this, it would have safely been assumed people would understand the message and take action in protecting themselves from HIV infection. Looking closely at the advertisement, an individual may wonder if the message or information is sufficient to motivate the general public to change their sexual behaviour. This in considering the demographic and socio-economic context in which people live play a crucial role in influencing sexual behaviour.

The safe sex message posters and advertisements were in all places so that everyone could see and read them. Oscar Motsumi, a programme officer commented concerning the information model of the 1990s “This country has been bombarded with HIV messages, but there hasn't been a change in behaviour”. Starting from 1997-2002, in addition to education and prevention information the Government added comprehensive care for those infected including antiretroviral therapy. Botswana was the first country in Africa to provide free antiretroviral therapy (ART) to its population, may be because she had the highest HIV incidence rate in the world at the time. The country initiated the ART programme in 2002 at four central sites. As of July 2003, 10 415 people were enrolled in the programme, the number being a tenth of 110 000 people estimated to be in need of ART (Stewart, et al. 2004:11). The country organized international assistance to address the epidemic and she also partnered and collaborated with international specialists from pharmaceutical corporations, universities, donor agencies, non-governmental organisations (NGOs), HIV/AIDS (UNAIDS 2004:169).

Founded on the beliefs in democracy, self-reliance, development, and unity, the Government emphasizes that by the year 2016 the negative impact of the HIV epidemic in Botswana will have been reversed (Vision 2016:71). Unlike all the other plans for the national response to HIV, the Government embarked on a National Strategic Framework, which differs from other plans in addressing HIV in that it is linked to the National Development Plan which directs parliament in

governing and developing the country. Besides, there is now the realization that HIV/AIDS is an on-going emergency which calls for planned, concerted and committed effort from all stakeholders.

**Figure 2.2**  
**Road Sign**



**Image by Andrew Petkun**

As of 2003 to date, there was multi-sectoral involvement of all partners and sectors and the government through the National AIDS Co-ordinating Agency which gave clear guidance of operations. Botswana's efforts in accosting the epidemic were endless including routine HIV-testing, education of young people, condom distribution and education, provision of antiretroviral drugs through the public health system and the introduction of life-skills training in the education curricula for both primary and secondary education.

In spite of all the efforts and funding that have been poured into prevention, treatment and care programmes, HIV/AIDS continues to be an unresolved snag in Botswana and Africa as a whole. Van

Niekerk (2005) commented “Never in the history of epidemics have we seen such a persistent increase in the number of people infected over such a prolonged period of time”. One may ask why government efforts are failing to stem the tide of HIV and AIDS, the answer may lie in that the government is not tackling the root causes or issues that greatly influence the spread. Addressing issues such as widespread illiteracy, poor education and extreme poverty is critical, issues of gender inequality, uneven distribution of wealth, unemployment, socio-economic insecurity, economic instability, stigma and discrimination, harmful social and cultural practices, migration and movement of populations. All these culminate in poverty. Poverty has been deemed a key factor in the spread of HIV/AIDS. The African Studies Centre, 2003, described poverty and AIDS as being interrelated, poverty exposes people to the risk of infection and it exacerbates the impact of HIV/AIDS. Focusing on HIV/AIDS by itself seems to have yielded minimal results; therefore concerted efforts are needed to break the cycles of deprivation. Women need to be empowered so that they are not totally dependent on men. The equitable distribution of wealth should be a matter of concern. Opportunities for further education and employment need to be created to better address the HIV/AIDS epidemic. The upliftment of poor communities is imperative if any significant change has to be realized.

## **2.5 CONCLUSION**

The literature reviewed is explicit in that HIV is a fatal virus and once an individual is infected there is no cure. The epidemic's worst impact is felt by the poverty stricken. Prevention efforts require understanding of powerful socio-economic forces that permit the diseases to arise and spread.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

Sim and Wright (2000:27) and Polit, Beck and Hungler (2004:164) suggest, “Research methodology is the overall approach adopted in a particular of research”. Specifically, methodology cites conventional principles of investigation that direct a study. This chapter will describe the research design, the research questions, the population, the sampling strategy, data collection methods and ethical considerations that were applied. The hallmark of the method chosen is its strength as a tool for investigating the relationship between socio-economic status and the practice of HIV self-protective/preventive behaviours.

#### **3.2 PROBLEM STATEMENT**

The study is intended to establish: Is there a relationship between socio-economic status and the practice of HIV self-protective preventive behaviours among the residents of Maruapula? A non-experimental, quantitative, exploratory and descriptive research design was used. The research will give an insight of the current socio-economic statuses and HIV preventive methods used by the residents.

#### **3.3 OBJECTIVES OF THE STUDY**

The objectives of the study were formulated to solve the problem pertained in the statement:

- To determine the residents’ knowledge of HIV self-protective/preventive behaviours.
- To assess underlying attitudes towards the practice of HIV self-protective/preventive behaviours.
- Identify gaps between residents’ knowledge and the practice of HIV self-protective/preventive behaviour.
- To assess the effectiveness of the response to the HIV epidemic.
- To assist in designing prevention services that is suited to the needs of the residents

### **3.4 RESEARCH APPROACH**

The research will employ non-experimental, quantitative and qualitative methodologies. It will use quantitative methods in order to investigate the relationship between socio-economic status and the practice of HIV self-protective/preventive behaviours. This will enable to identify if there is any association between socio-economic status and the practice of self-protective/preventive behaviours. Apart from data which will be collected specifically for this project, raw data from BAIS II (Botswana Aids Impact Survey) will be sought and subjected to similar statistical analyses in order to provide solid evidence regarding the relationship between socio-economic status and the practice of HIV self-protective/preventive behaviours. Responses from people of different socio-economic statuses will be studied to investigate how socio-economic factors affect individuals' perception of vulnerability to HIV infection. Brink (1999:108) underscores "a non-experimental study is carried out in a natural setting and the phenomena are observed as they occur" data can be gathered without making modifications or introducing treatments. The research selected this design because data could be collected in the natural environment. The non experimental was deemed appropriate since the research is intended to expound or interpret underlying causes of variables of interest (Polit and Hungler 1999:175). Some characteristic associated with people are inherent and cannot be subject to experimental control. Variables in this study concern socio-economic status and knowledge and practice of HIV prevention methods hence the appropriateness of the design for the present research.

### **3.5 SAMPLING**

The study will be carried out in Maruapula residential area in Gaborone, Botswana. The residence is about 3km from the city's main mall. The houses in the residential area comprise of what is known as high cost (mansions), middle cost, (standard three bed roomed houses), low cost (2-3 bed roomed houses) and compound like houses, some with no plans.

Sampling is the process of selecting people, events, behaviours or other elements with which to conduct a study (Burns & Grove 1997:341). They described a sample as a small portion of the population that is being studied in a particular location or setting. A number of 30 randomly chosen respondents are deemed to be adequate considering everything else including time and funding constraints. This sample is deemed to be representative in that all sections of social economic status are represented. The random sample is important because the researcher intends to generalize directly to a population based on a single research study results. It is assumed the people who live in mansions are rich and those who live in compounds are poor. The researcher will develop a sampling frame by giving the elements identification numbers, then drawing a random sample. The randomly selected respondents will be the final sample. The sample will reflect the relationship between socio-economic status and the practice of safe sex in the community. The technique by which the sample was chosen

is vital to the discussion and the validity of the research findings. Eligible men and women have to be 18 years and older, normally resident in Maruapula and mentally competent to complete the questionnaire.

### **3.6 DATA COLLECTION INSTRUMENTS**

Two structured questionnaires, one Likert scale containing two or more items will be used to elicit responses from the subjects chosen in the study. The second questionnaire, the Likert scale, containing 35 questions will be used to elicit information about a) the residents' knowledge of HIV self-protective/preventive behaviours. b) To assess the underlying attitudes towards the practice of HIV self-protective/preventive behaviours. c) To identify gaps between the residents' knowledge and available support services. The questionnaire was identified as the most appropriate instrument of gathering easily quantifiable, specific data for a holistic understanding of the problems associated with developing HIV prevention interventions for the residents. The questionnaire is readily available and the information is collected firsthand. The chances of misinterpretations and misreading of questions and responses by both the researcher and respondents are limited. The questionnaire addresses pertinent questions about socio-demographic characteristics, including age, gender, marital status, educational level and employment status, behavioural and biological factors of HIV infection and its prevalence. There are 25 questions in the questionnaire. The questions are specifically selected to yield answers required for the study. In the questionnaire, the items do not have correct answers and some items are worded positively while others are worded negatively. This questionnaire is also designed to assess underlying constructs that are quantifiable. Care was taken to ensure that the questions are not leading, biased or ambiguous, double barreled, thus the questions are comprehensive and easy to understand. The questionnaire will be presented in English and translated into the local language for those that will prefer to respond in the local language to ensure there is understanding of what is expected from the respondents.

### **3.6 CONCLUSION**

Having carried out the research as above detailed, the results will show whether a relationship exists between socio-economic status and the practice of HIV self protective behaviour.

## CHAPTER 4

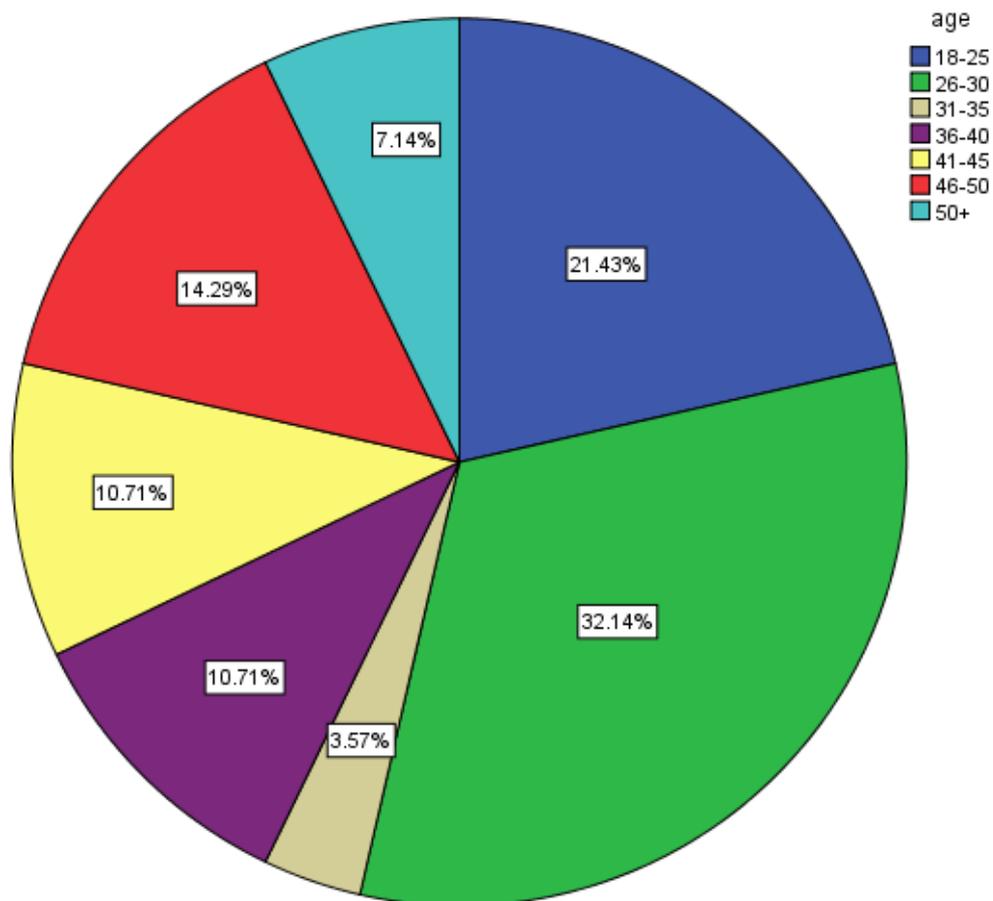
### REPORTING OF RESULTS

#### 4.1 INTRODUCTION

The Statistical Package for Social Sciences (SPSS) was used to analyze all the data, the demographic, socio-economic and HIV knowledge and prevention data. Collected data was analysed using descriptive statistics, which are frequencies and percentages. Section 4.2 shows the demographic information while section 4.3 gives the socio-economic data of the participant. Figure 4.1 shows the ages expressed as percentages of the people who participated in the research.

Figure 4.1

#### DEMOGRAPHICS



According to figure 4.1 the following was established:

- The majority of the respondents, 89.57% are 26 years and above.

**Table 4.1**

**MARITAL STATUS**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid single	15	48.4	53.6	53.6
married	9	29.0	32.1	85.7
living in union	3	9.7	10.7	96.4
divorced	1	3.2	3.6	100.0
Total	28	90.3	100.0	
Missing System	3	9.7		
Total	31	100.0		

- From the results shown on table 4.1, only 29% of the respondents are married. The majority 48% being single while and the rest are either living in union or divorced. The people who claimed to be single have sexual partners. It is assumed that they claimed to be single because they do not have a permanent or a live-in partner.
- The results are in agreement with the findings of BAIS II.

**Table 4.2**  
**EDUCATION**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid none	2	6.5	6.9	6.9
primary	6	19.4	20.7	27.6
secondary	5	16.1	17.2	44.8
post-secondary	7	22.6	24.1	69.0
other, specify	9	29.0	31.0	100.0
Total	29	93.5	100.0	
Missing System	2	6.5		
Total	31	100.0		

- After its economic boom due to the discovery of diamonds, the government invested heavily in education and ensured that all children got at least ten years of basic education. The findings from this research confirm this as shown on the pie chart. UNESCO (2011) statistics show that there was a 92% of primary education completion with 97.3% proceeding to secondary school. Botswana's public spending on education being 21.5% of the total public spending by government. The above information leaves no doubt of the government's commitment to make education accessible to all regardless of gender, disability, social class or ethnic group.
- Only 6.5% of the participants had no education. After independence, the government of Botswana expanded its educational provision to the extent that everyone was reached. The 6.5% of those who have no education maybe members of a sect commonly known as 'Bazezuru.' This sect does not subscribe to school education because they believe school education corrupts their children and they become misfits and delinquent. Instead, the children are apprenticed into trades such as metal work, basketry for boys and stitchery and small trading for both boys and girls. Of noteworthy is that this sect confines its social and sexual relationships to sect members.

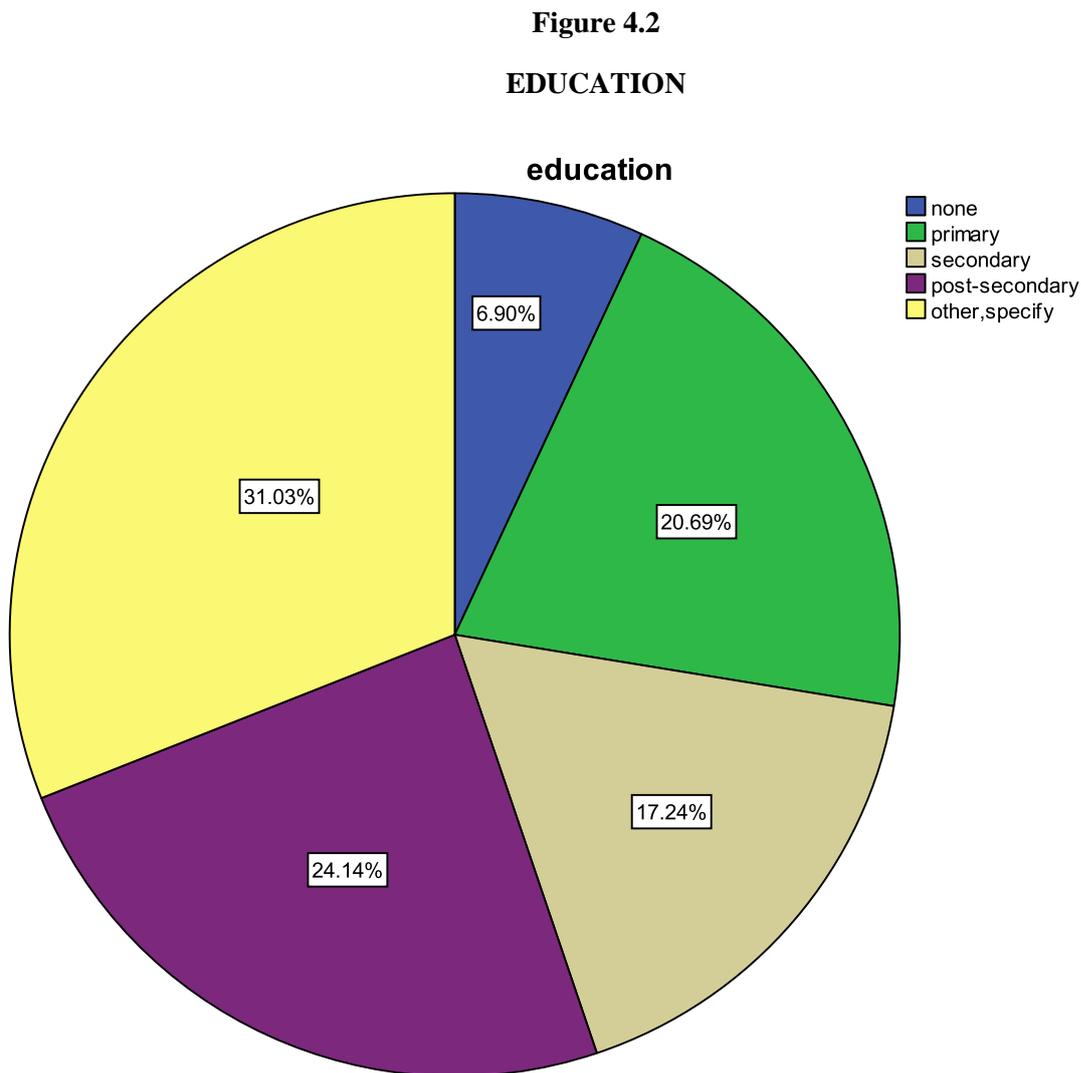
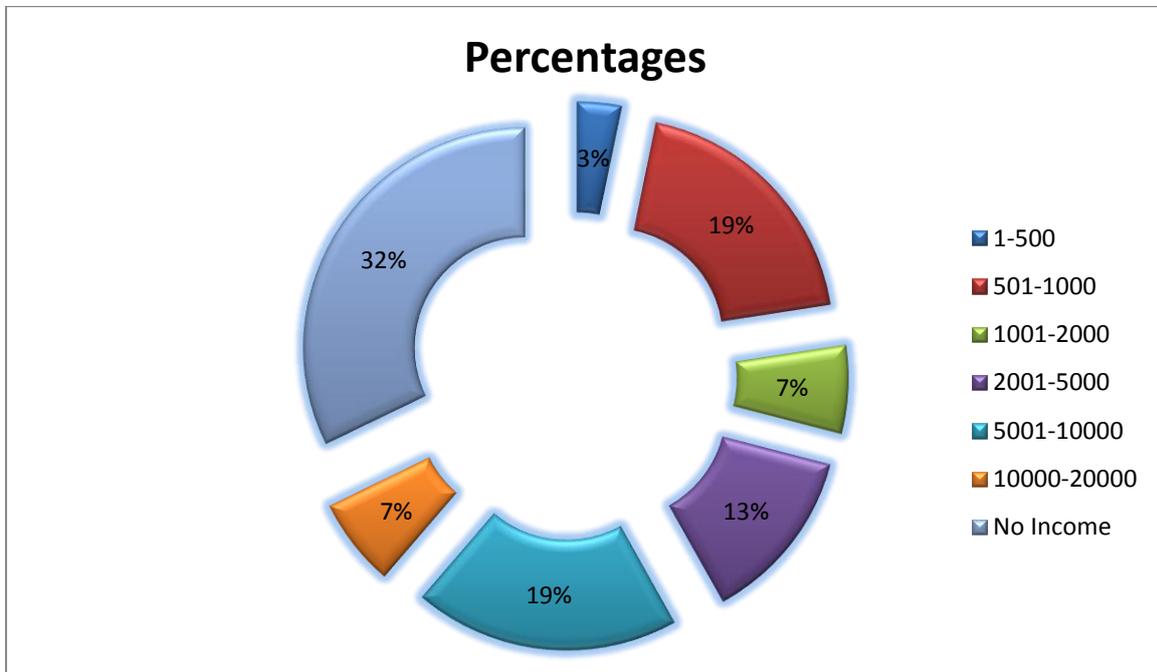


Figure 4.2 demonstrate the academic attainments of the residents who took part in the survey.

- Only two, 6.6% of the sample had no education at all and they are both above 46 years old.
- The people who had either primary or secondary education were seven, 26.6% and so where those with post secondary and university education.
- The results that came out show high levels of literacy. This is in agreement with what BAIS II found out. This is a positive trend because it can be assumed that the majority of people can read and understand HIV prevention messages (table 4.2 and figure 4.2).

**Figure 4.3**  
**EMPLOYMENT AND INCOME**



- Figure 4.3 show that a significant percentage 32% of the respondents has no income. And it is presumed that these people are unemployed.
- The people who are employed are 68%.
- Of those that are employed, 29% earn a monthly salary of P2000 and below.
- The respondents who get a monthly in income of between P5001 and P10000 are only 19%.
- Those who can be considered to be of high socio-economic status based on their income are just 7%.
- It is worth noting that the percentages of people who have secondary education and higher 72% and the percentage of people who earn a reasonable income of P5000 per month do not correspond. Merely 26% earn P5000 and above.

**Table 4.3**  
**EMPLOYMENT**

	PERCENT
Yes	51.6%
No	41.9%
Missing	6.5%

Table 4.3 show employment data.

- Unemployment is quite high standing at 41.9%. This is agreement with UNESCO findings of employment with primary and secondary education standing at about 60%.
- 6.5% Of the respondents did not respond the employment question, it is presupposed that they are not employed, making the percentage of the unemployed about 48%.

**Figure 4.4**  
**SOURCES OF POWER**

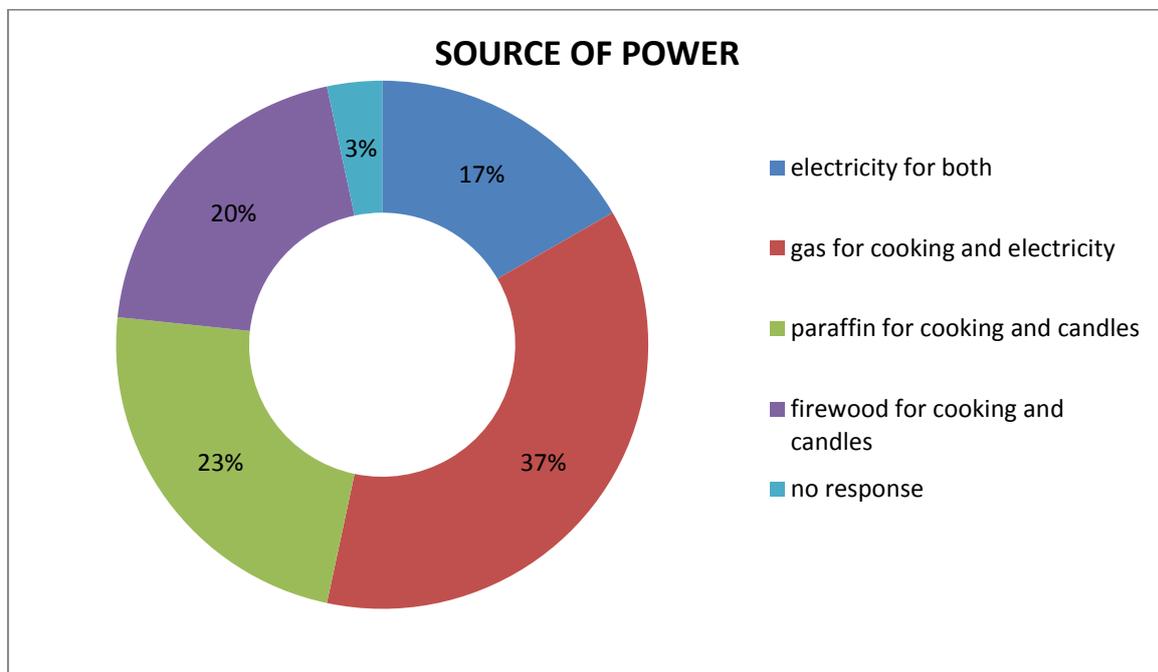


Figure 4.4 illustrate the response to the question that enquired the source of power for cooking and lighting.

- 17% of the participants use electricity for both cooking and lighting.
- A considerable 37% use gas for cooking and electricity for lighting. This is understandable because Maruapula is an urban settlement and Botswana has made great strides in electrification even in the rural areas.
- A majority of the respondents, thirteen, and 43 % used either paraffin for cooking and candles for lighting, firewood for cooking and candles for lighting

**Figure 4.5**

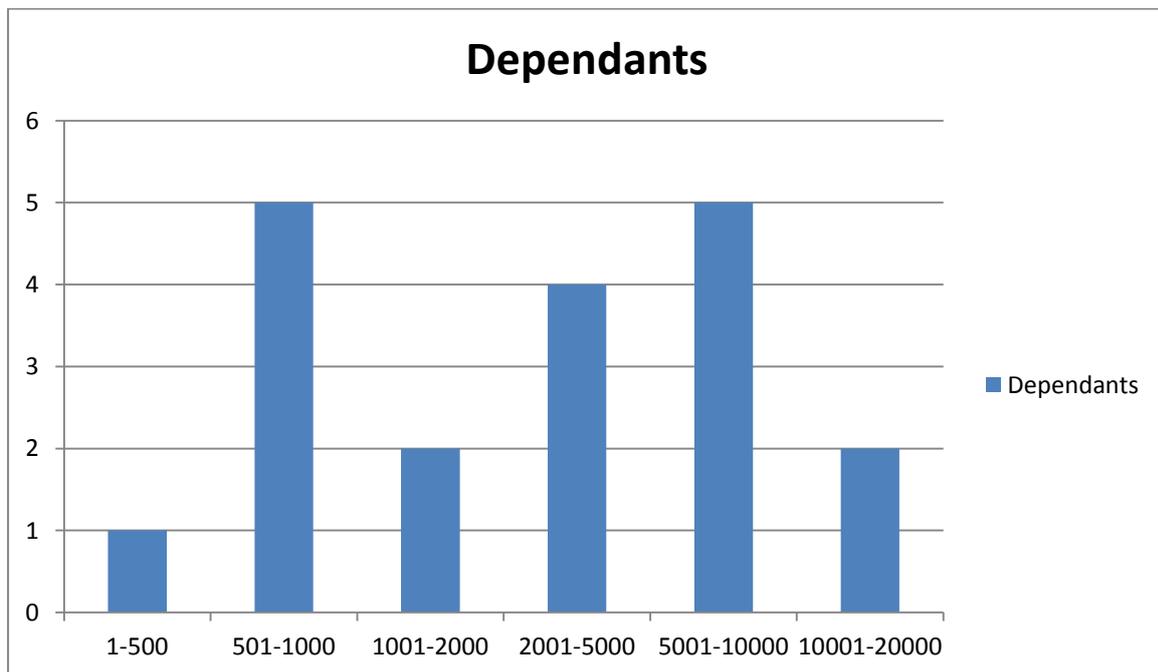


Figure 4.5 demonstrate the respondents' incomes relative to the number of their dependents.

- The number of dependants is in most cases disproportionately matched with the income, for an example there are incidences of someone who has an income of between P500 and P1000 but having 5 dependants.
- The people who have a good income of between P10000 and P20000 are the ones with only two dependants.

Figure 4.6

## CAR

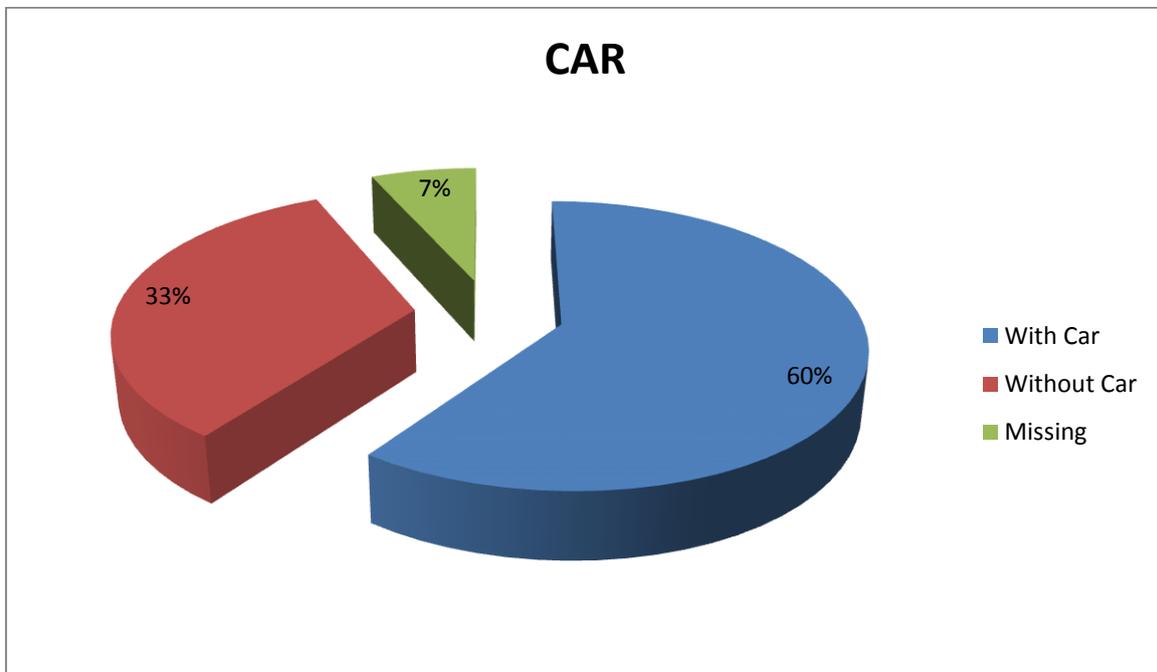


Figure 4.6 show the percentage of respondents who own cars.

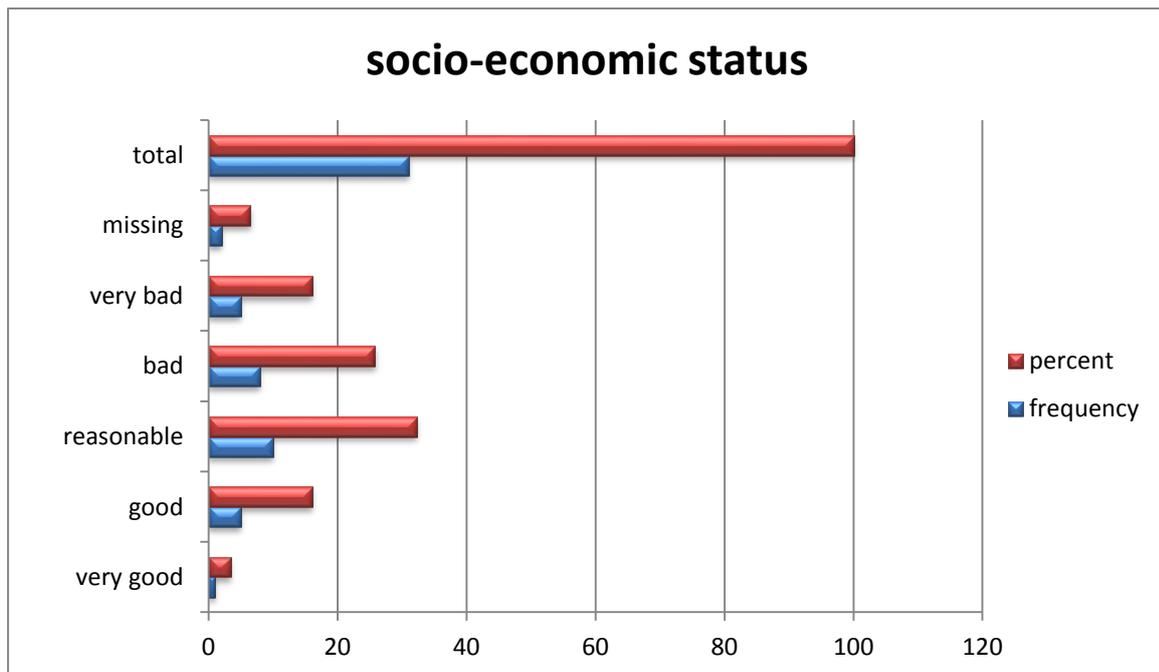
- 60% have cars while 40% of the participants do not own cars.
- The large number of car owners is not proportionate with the income of the majority, 40% who have incomes of P5000 or less.

**Table 4.4**  
**ECONOMIC STATUS**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid very good	1	3.2	3.4	3.4
good	5	16.1	17.2	20.7
reasonable	10	32.3	34.5	55.2
bad	8	25.8	27.6	82.8
very bad	5	16.1	17.2	100.0
Total	29	93.5	100.0	
Missing System	2	6.5		
Total	31	100.0		

**Figure 4.7**

**SOCIO-ECONOMIC STATUS**



- When asked to judge their own socio-economic status, a majority, (thirteen, 41.9%) deemed it to be either bad or very bad. This is also evidenced by the type of housing they have, the income they get and the source of power they use. Besides, the number of people who depend on their income testifies to a bad socio-economic standing.

#### 4.3.1 KNOWLEDGE ABOUT HIV AND HOW TO PREVENT IT

**Table 4.5**  
**CAUSE OF HIV AND AIDS**

CAUSE OF HIV and AIDS	FREQUENCY	PERCENT
Witchcraft	1	3.2
Virus	15	48.4
prostitution	3	9.7
Not using a condom	9	29.0

Table 4.5 represents the responses to the question which asked about the cause of HIV infection.

- Many of people (fifteen, 48%) are aware that HIV and AIDS is caused by a virus. However, noteworthy is that a significant number think HIV is caused by not using a condom.

**Table 4.6**  
**CONDOM USE**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	22	71.0	75.9	75.9
no	7	22.6	24.1	100.0
Total	29	93.5	100.0	
Missing System	2	6.5		
Total	31	100.0		

Table 4.6 shows the responses to the question which asked if they used condoms with sexual partners. Participants who claimed that they use condoms frequently are 71%. Those who do not use condoms are 29% including those who did not respond to the query who are assumed not to use.

**Table 4.7**  
**USED CONDOM DURING LAST SEXUAL ENCOUNTER**

	<b>FREQUENCY</b>	<b>PERCENT</b>
YES	18	64.1
NO	10	32.3
MISSING	3	9.7

Table 4.7 illustrates the use of condoms at the last sexual encounter.

The statistics indicate 75.9% claimed they use condoms consistently when having sex, but on the next question which asked if they had used a condom recently, less than half, 44.8% said they had used. Those who did not respond to the question are taken for granted that they do not use condoms at all.

**Figure 4.8**

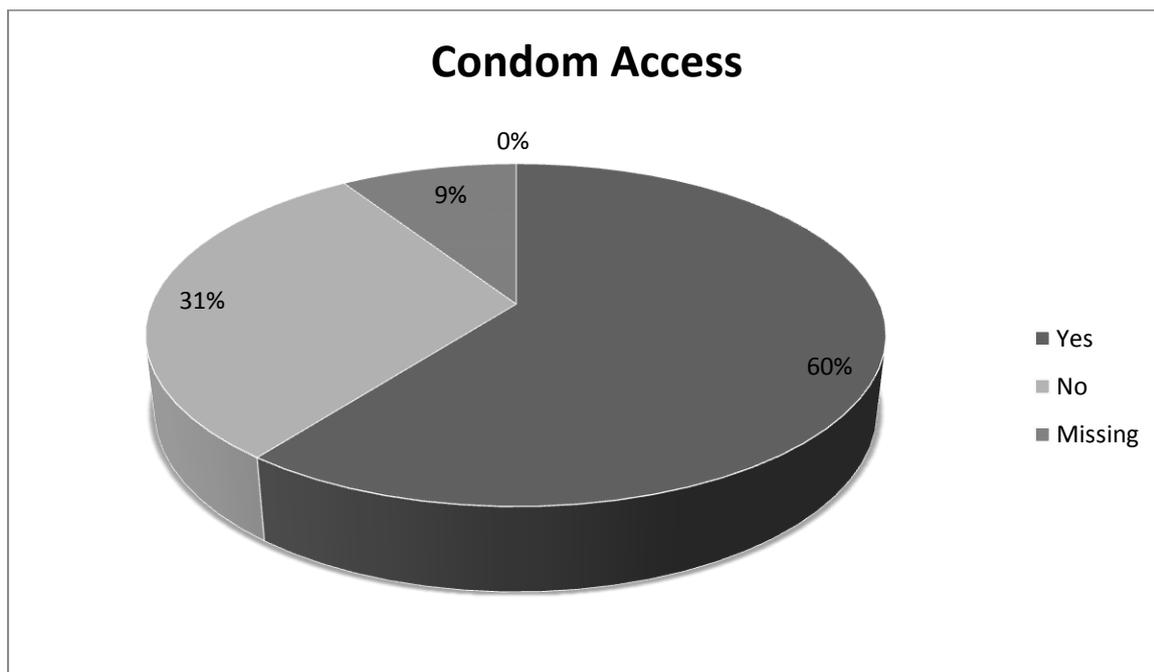


Figure 4.8 shows availability of condoms.

- 60% pointed out that they had easy access to condoms, and that they are government provided condoms accessed only at clinics.
- Respondents who allege that they have no easy access to condoms are 31%.
- The 9% who did not answer the question maybe those who do not use condoms at all.

**Table 4.8****I DO NOT NEED TO TEST FOR HIV BECAUSE I AM HEALTHY AND STRONG**

	FREQUENCY	PERCENT
Strongly agree	2	6.5
Agree	4	12.9
Disagree	12	38.7
Strongly disagree	12	38.7
Undecided	1	3.2

Table 4.8 show what the respondents think about HIV testing.

- The participants (77.4%) think they should test for HIV even if they look healthy and feel strong.
- Only 19.4% think that if they look healthy and feel strong, there is no need for testing for HIV.

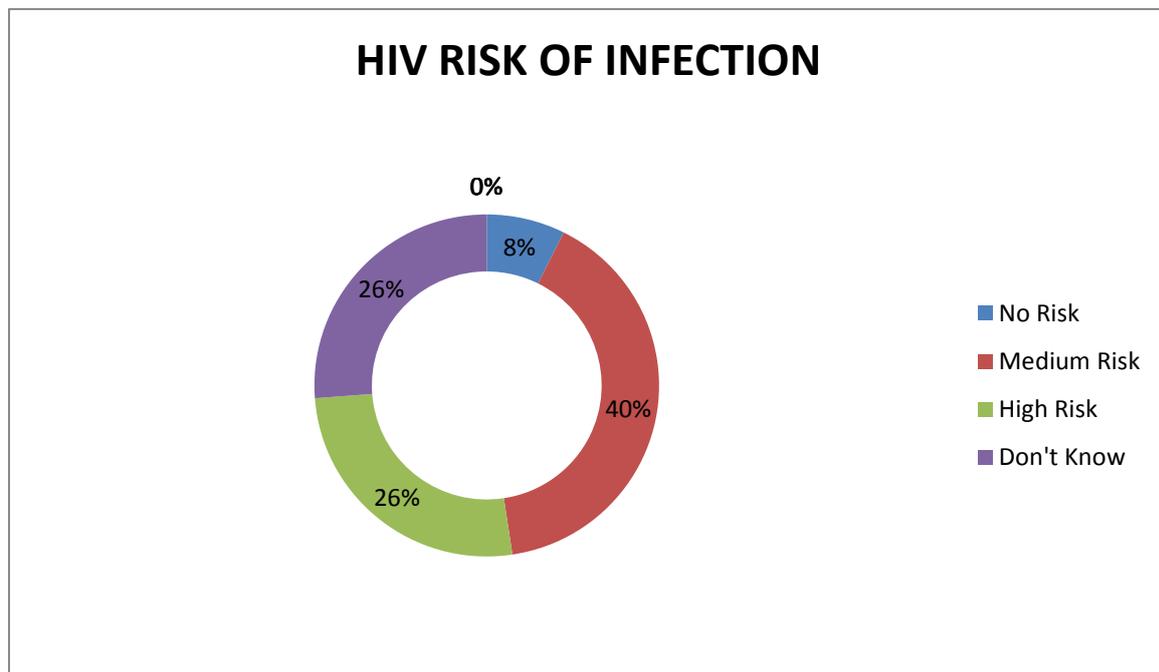
**Figure 4.9**

Figure 4.9 represents the percentages of how the participants perceive themselves regarding the risk of HIV infection.

- A mere 8% of the respondents consider themselves to be at no risk at all.
- The people (40%) regard themselves as having a medium risk of contracting HIV,

Individuals (52%) either think they are at high risk or they do not know.

**Figure 4.10**

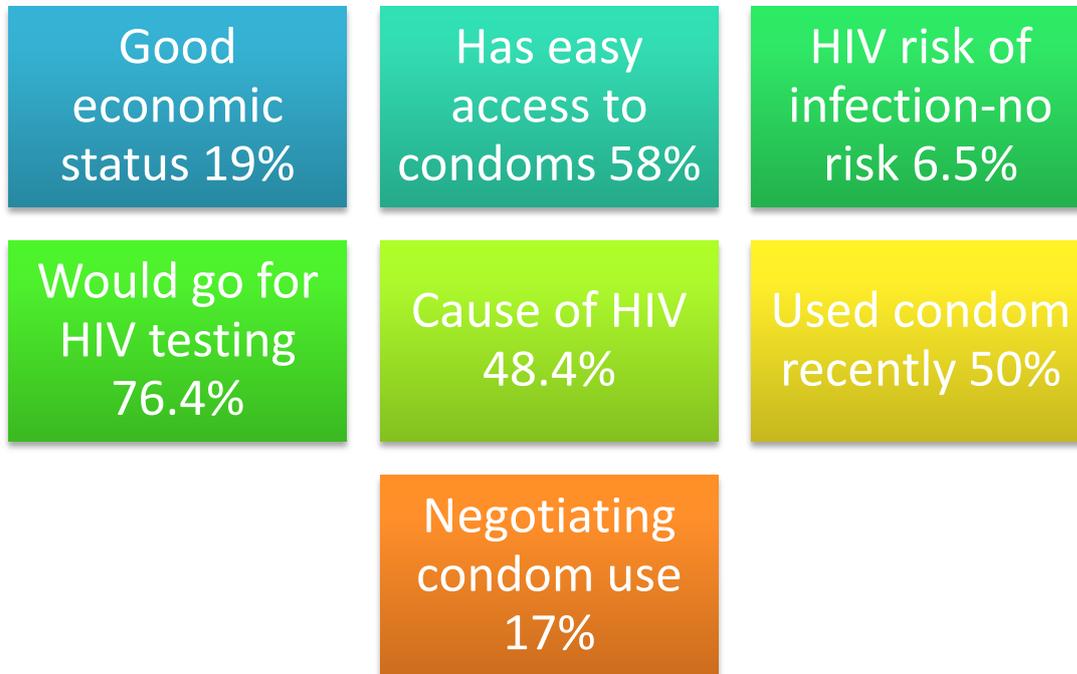


Figure 4.10 reflects the respondents' socio-economic status and their practice of HIV/AIDS self-protective/preventive behaviours.

- According to their own judgment, 19% have a good socio-economic status.
- 58% have easy access to condoms, these are government provided condoms accessed only at the clinic.
- About 50% used condoms when having sex recently, but 71% claimed that they normally use condoms.
- 76.4% agree that it is necessary to have an HIV test to avoid infecting others
- 6.5% perceive themselves to be at no risk of HIV infection at all.
- Only 17% find it difficult to negotiate condom use with their partners.

#### 4.4 CONCLUSION

The goal of the chapter was to make sense of the data that was gathered. After summarizing and describing the research data, it is possible to draw conclusions. Moreover data presentation and analysis enables others to understand and perceive distinctive attributes of an issue. Not every item from the questionnaires was presented graphically but the very important ones. An attempt was made

to tabulate and graphically present the pertinent variables in evaluating socio-economic factors and HIV preventive behaviours. The first section, demographic data, gave an insight into the age, marital and employment status of the respondents. The biggest percentage was in the age range 18-45 years, which is the economically productive age. Many people in the sample, 64.3% are either single or living in union. This trend is common in the whole of Botswana as evidenced also by the findings of BAIS II (2005). The following chapter will give detailed conclusions based on the objectives of the study. Furthermore, the researcher will give recommendations that may be useful in achieving “zero new infections” by 2020.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENTATIONS

#### 5.1 INTRODUCTION

The study's aim was to establish whether there is a relationship between socio-economic status and the practice of HIV self-protective/preventive behaviours in Maruapula. Having analyzed the results from the collected data, a number of conclusions and some recommendations are going to be made.

The problem statement of the study was formulated as: Does socio-economic status influence the practice HIV-self protective/ preventive behaviours among residents of Maruapula?

#### 5.2 CONCLUSIONS ON DEMOGRAPHIC AND SOCIO-ECONOMIC DATA

A high percentage of people are literate having attained at least primary education. Those that proceeded to secondary or post secondary are the majority, standing at 41.38%, (secondary education ranges from Form 1-Form 5, and post secondary means any qualification that is not university education). Again, these statistics confirm findings by the BAIS II and the National census of 2011, which found Botswana to have a very high literacy level. Although the country has a very high literacy rate, unemployment is equally high among the population of the study standing at 55.3%. Those that are employed are many in the unskilled and semi-skilled jobs. Their incomes/earnings of below P5000 are a testimony to this. Besides, low salaries, the researchers found that quite a number have people dependent of their paltry incomes. For example, 20% of people with an income of less than P5000 have charges ranging from two to five. Considering the high cost of living in Botswana, and Gaborone in particular, one wonders how they make ends meet. The people's type of accommodation also reflects disparities between income, and financial obligations. Quite a number of people live in either one room or two rooms (65.5%) with the dependents. In most instances the room serves as the kitchen, bedroom, sitting room and bathroom, no wonder why people of different ages are always seen loitering in the streets and around shops. The researcher required the participants to judge their own socio-economic status and many (41.9% and 6.5% who did not respond) were honest enough to evaluate it as either bad or very bad. This revelation from the study, ties up with the suggestion in the background of the study where the researcher observed that in one section of Maruapula, people live in dire poverty.

The analysed data clearly shows the majority of participants have a low socio-economic position. This is evident from the level of education of most with only about a third having attained professional qualifications and earning above P5000. The living conditions also tell of the low socio-economic standing. The one room and two rooms they occupy lack proper sanitary amenities. The toilets are pit latrines that have no flush system. Usually the latrine is used by more than ten people. Bathing is done in the room in plastic bowls. Despite having a measly income, most people have to support one of more people. Though education is almost free in Botswana, there are transport costs that one has to bear. Transport is quite cheap, though for someone living on P2000 per month it can be straining. Food is the most expensive, but most locals are content with the staple 'mabele' which they make into porridge and eat with sugar mostly.

### **5.3 KNOWLEDGE OF HIV PREVENTION OF HIV SELF-PROTECTIVE BEHAVIOURS**

#### **OBJECTIVES OF THE STUDY**

- To determine the residents' knowledge of HIV self-protective/preventive behaviours.
- To assess underlying attitudes towards the practice of HIV self-protective/preventive behaviours.
- Identify gaps between residents' knowledge and the practice of HIV self-protective/preventive behaviour.
- To assess the effectiveness of the response to the HIV epidemic.
- To assist in designing prevention services that is suited to the needs of the residents

As illustrated in the table and graph, more than half of the respondents know that HIV infection is caused by a virus. Those who thought HIV is caused by either witchcraft or prostitution were 12.9%. A significant number, 31.9% were of the opinion the HIV is caused by not using a condom. The data also reveals that generally, people use condoms (71%). When asked if they had used a condom the last time they had sex, apparently several had not (51.6%). The fact that 71% of the people claimed that they normally use condoms implies that the majority from high, middle and low socio-economic status use condoms, though why, about 52% did not use condoms the last time they had sex is puzzling. Amongst other fundamental questions, the researcher asked about negotiating condom use with sexual partners and the number of sexual partners one had. The results reveal that only 17.1% could not negotiate condom use with partners, the rest alleged that it was not a challenge. All of the participants professed to be having only one sexual partner, not knowing whether they meant one current partner or not. HIV/AIDS knowledge and prevention knowledge are widespread in Botswana. In a separate study, the researcher was told by a participant, 'I don't think there is anyone in Botswana who hasn't heard about HIV/AIDS and the ways of preventing it.' AIDS has been around for so many years and the government has ensured that everybody gets the message; it is talked about so much just

like the gospel, to draw a parallel. The question that asked if they had heard about HIV and how to prevent it was not even analyzed because a 100% answered in the positive. Organizations such as the Youth Health Organization (YOHO) and others have played a crucial role in awareness campaigns and education. There have been further initiatives such as Makgabaneng, a production broadcast on radio with the aim of campaigning for the practice of safe sex behaviour. The Total Community Mobilization, Humana People-to-People's initiative made great strides in educating and helping infected and affected people, (HIV& AIDS in Botswana 2011:4). The African Comprehensive HIV/AIDS Partnerships (ACHAP) and the Botswana U.S.A Project (BOTUSA) partnered with the government and embarked on extensive prevention programmes. In summary, the following are HIV prevention programmes in Botswana:

- Public education and awareness
- AIDS education for young people
- Condom distribution and education
- Targeting high risk adult populations
- Improvement of blood safety
- Prevention of mother-to-child transmission

Lately, there has been a scale-up in the provision and access to ARVs. Unlike other SADC countries, Botswana is privileged by having the highest donor funding in the region, (Hassim 2005) attest that Botswana obtains almost 30 times more financial support per capita than several other countries in sub-Saharan Africa. Individuals on treatment with ARVs are purported to be less infectious because the viral load will be very low or undetectable. There also has been the introduction of male circumcision which was discovered to reduce HIV contraction by about 70%. The above supports the research findings and related literature that there are high levels of knowledge of HIV self protective/preventive methods. Then why is it that there are still new infections when people have such an abundance of knowledge and resources at their disposal to prevent infection. The implication is that people are still practising high-risk behaviours such as inconsistent condom use and having multiple sexual partners. The present research actually confirms this since just 51.1% of the sample disclosed that they did not use a condom the last time they had sex. In spite of professed easy access to condoms, it remains a surprise why people take such risks. Almost everyone indicated that they had a single sexual partner, but what they meant might be one partner at that particular time. Since the people marry late or do not marry at all, they may have several sexual partners before the settle.

In summary, Botswana has invested billions of dollars in prevention attempts, and the people nowadays have all the facts and information about HIV/AIDS. This knowledge seems to have had no

impact or a slight effect on behaviour change necessary for the decrease in transmission levels across the age ranges. The inference is that preventive knowledge by itself is insufficient to translate to lasting behaviour change.

#### **5.4 UNDERLYING ATTITUDES TOWARDS THE PRACTICE OF HIV PREVENTIVE BEHAVIOURS**

HIV testing is a crucial step in relation to prevention of infection. The researcher wanted to know if people were willing to be tested or had tested, a whopping 76.4% maintained that they have either tested or are willing to be tested again to avoid infecting others. There were some questions that were asked about drinking and having sex, the researcher found these to be relevant because as mentioned in the background, people in Botswana in general and in Maruapula in particular people drink excessively. Most respondents (81%) agreed that drinking and having sex go together and that one should not drink and have sex. A considerable percentage (38.7%) of people in the research expressed that instead of the government worrying about HIV, it should worry about things that concern them such as employment. Also, 38.7% asserted that for them, there too many worries that concern them so HIV is not top on their priority list.

Generally, people of Botswana are heavy drinkers of alcohol. In every address to the nation, President Khama grieves over alcohol abuse. Hence, “for excessive drinking is itself a breeder of poverty, delinquency and inefficiency, as well as poor mental and physical health. There is a recognised link between excessive alcohol use and risky behaviour that contributes to the spread of the HI virus. We are aware of the role substance abuse plays in treatment default for other illnesses such as TB. Alcohol is also a contributing factor to a wide range of additional maladies,” (Khama, 2012). In spite of a majority (68%) agreeing that one should not drink before having sex, the people continue to drink in excess. This made the government to take drastic measures to curb the misuse of alcohol. Such measures included enhanced law enforcement; reduction in the hours of sale of alcohol; and a 30% tariff on alcoholic beverages.

## **5.5 THE RELATIONSHIP BETWEEN SOCIO-ECONOMIC STATUS AND THE PRACTICE OF HIV PREVENTION**

If there is any relationship at all between socio-economic status and the practice of HIV self protective behaviours, it was not evident in the present study. Most people considered to be of higher socio-economic status were the ones who pointed out that they had not used condoms in their last sexual encounter. While this may signify risky behaviour, another explanation may be that they are settled in their relationships and they are faithful to one another. Even though there is a consensus among researchers suggesting that a relationship exists between poverty and HIV infection, this has not been substantiated. Shaikh and Borat (2005) state that there is very little empirically robust information on the social and economic correlates of the HIV/AIDS epidemic. Casale and Whiteside (2006) contend that, "little recent research explores the influence of socio-economic variables on the risk of contracting HIV." Rather, sexual behaviour, risky or safe is modelled by numerous factors inherent in the society, including social, economic and cultural.

Although being poor does not cause HIV infection, the link between the two lies in that needy people are likely to lack the motivation to practice safe sex. The incidence of poverty, which has a direct link to unemployment, may also culminate in risky sexual behaviours. HIV contraction may have low priority for people living in severe and chronic poverty and are constantly concerned about survival issues. Poverty and unemployment are globally associated to alcohol consumption and sometimes using drugs and smoking dope. These reduce levels of inhibition and may result in the practice of HIV risky behaviour. Drinking seems to be a major problem and a major contributor to the extent of the epidemic in Botswana, (BAIS II, 2005).

## **5.6 RECOMMENDATIONS**

HIV/AIDS prevention in sub-Saharan Africa and Botswana in particular should seek to change the behaviours of persons at the same time focusing on the socio-economic frameworks in which the people exist. Poverty stricken people have too many current worries that may constrain their desires to reduce the risk of HIV infection. There should be an attempt to merge economic empowerment with HIV prevention. In trying to address the problem of HIV/AIDS, the government and all stakeholders should consider the input of the community. This is because a community is an expert on itself. They know what barriers hinder the utilization of HIV self-protective measures. They can identify priorities and needs. People in the community know best how they can be helped and what will and will not work. There is need to gain insight about barriers, that impede successful interventions for HIV/AIDS in the community. These may be social, economic, political or spiritually barriers. The response to HIV/AIDS must acknowledge the individuals in the context of what they may be facing, not just

HIV/AIDS. This entails recognizing that the individual may be facing one or more of a set of issues including housing, food insecurity, safety, alcohol and drug abuse, poverty and others. In the face of all the challenges one may be facing, HIV/AIDS may not be high on the priority list on a day-to-day basis. As a result, it may be necessary to go where the consumers are; that is, to identify their need priorities, working with the individuals in relation to their needs, and address HIV/AIDS as one element to be addressed among many challenges. Furthermore, AIDS has been killing older people who are sixty and above, prevention strategies such as condom use must also target them because men in this segment indulge in sexual intercourse with younger women as well. Lastly, local and cultural belief systems need to be taken into account, including the convention of sex.

## **5.7 ADDRESSING LIMITATIONS**

Communities are not only the frontier of AIDS—they should be the vanguard of the response. Hence they need to be mobilized before any research or programme takes place. Therefore communities are requisite stakeholders in the fight of the outbreak. Any initiative that will succeed needs to come from the community even as they acknowledge that there is a problem. As observed before, a community is an expert on itself and if it comes from them, they will hold themselves accountable. Given the chance, they will articulate better the issues of concern and requirements in their area and advise on how these can be tackled. When HIV researches are done in a community, it is expected that something is going to be done in response to the findings. The common trend in Africa is that a research is carried out and that is the end of it. In HIV prevention approaches, there is need to ensure that mobilization cut across the socio-economic strata of society. Then whatever programme is considered to be necessary should be tailored to the specific needs of community that was studied and the most vulnerable populations, including poor youth, women and the other most at risk populations such as sex workers and men who have sex with men. Monitoring and evaluation plays a crucial role in accosting HIV/AIDS and indeed any other thorny issue. Once projects have been established there is need for effective and continual monitoring and evaluation, otherwise efforts will be in vain.

## **5.8 CONCLUSION**

Botswana's response to HIV/AIDS has been quite plausible. All her programmes hinged on education and information, testing, PMTCT, condom distribution and ARV treatment programme. All these have been rather ineffectual because they did not address the root cause or the determinants of the spread of epidemic. Besides, the need to reach varied communities and social groups was not met. Communities have to be consulted to clearly articulate their concerns and to enlighten on existing beliefs and practices prevalent in the community that put people at risk of HIV infection. Important questions such as the following may need to be answered to successfully contain the epidemic:

- Are people aware of their individual and collective vulnerability to HIV/AIDS?
- How can access to HIV prevention and other health related services be increased or improved?
- What can be done to promote linkage to continuous healthcare and treatment?
- What other immediate needs is the community concerned about that may obstruct focus on HIV/AIDS prevention?

Until the way of the response to HIV/AIDS changes, the plague will continue to prevail.

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AFRICA CENTRE FOR HIV/AIDS MANAGEMENT

28 May 2012

Gaborone City Council

Gaborone

Botswana

Dear Sir / Madam

**Re: Intention to conduct a research project in Maruapula Residential Area**

Mrs. Sarah Mberengo, a Master of Philosophy student in HIV and AIDS Management (Student Number: 16860500), at the Africa Centre for HIV/AIDS Management at Stellenbosch University proposes to carry out a research at Maruapula residence. The study is about "An investigation into the relationship between socio-economic status and the practice of safe-sex among residents of Maruapula."

The participants will be 30 people who are living and have been resident in Maruapula for the past 12 months. A sample of thirty 30 randomly selected people, with equal male and female representation will be selected. The Selected participants will be given an anonymous self- administered questionnaire that contains both open and close ended questions asking about socio-demographic characteristics, behavioural and biological factors of HIV infection. Some participants will be interviewed by the researcher using the same questionnaire. The completed questionnaire will be collected and all necessary precautions will be taken to ensure that the questionnaires are not accessible by any other person. The research is for academic purposes, but may help in informing local level interventions and in designing prevention services suited to the needs of the residents.

We therefore kindly request permission for Mrs. Mberengo to carry out this study in the above mentioned residential area. The study should run between August and September 2012. Feel free to contact us if you have any further questions.

Kind regards

Kind Regards,



Burt Davis

Lecturer

Africa Centre for HIV/AIDS Management

STELLENBOSCH UNIVERSITY | Private Bag X1 | Matieland 7602 | RSA

T: +27 21 808 3006 | F: +27 21 808 3015

E: [burt@sun.ac.za](mailto:burt@sun.ac.za) | W: [www.aidscentre.sun.ac.za](http://www.aidscentre.sun.ac.za)

TELEPHONE:3658400  
TELEGRAMS:  
REFERENCE:CLG14/14/3/1/IXX (32)  
FAX:3952382/3952384



REPUBLIC OF BOTSWANA

MINISTRY OF LOCAL GOVERNMENT  
PRIVATE BAG 006  
GABORONE  
BOTSWANA

August 01, 2012.

Mrs Sarah mberengo  
Private Bag BR 06  
Gaborone

Dear Madam,

**RE: RESEARCH PERMIT**

This serves to acknowledge your application for a research permit in order to do a study entitled "**The Relationship Between Socio-Economic Status and the Practice of Safe Sex Among Residents of Maruapula, Gaborone.**"

The permit is valid for a period of one (1) month – commencing on August 01, 2012 to September 01, 2012 – and it is granted subject to the following conditions;

1. Copies of the final product of the study are to be directly deposited with the Ministry of Local Government, Ministry of Finance and Development Planning, National Archives and Record Services, National Library Service and University of Botswana Library.
2. The permit does not give you authority to enter any premises, private establishment or protected areas. Permission for such entry should be negotiated with those concerned.
3. You conduct your study according to particulars furnished in application you submitted taking into account the above conditions.
4. Failure to comply with any of the above stipulated conditions will result in the immediate cancellation of the permit.

Yours Faithfully,



cc: PS, Ministry of Finance and Development Planning  
PS, Ministry of Labour and Home Affairs  
Director, National Archives and Records Services  
Director, National Library Service  
Director, Research and Development, University of Botswana.



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**CONSENT TO PARTICIPATE IN RESEARCH**

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**The relationship between socio-economic status and the practice of HIV self-protective/ preventive behaviours among the residents of Maruapula, Gaborone**

You are asked to participate in a research study conducted by Sarah Mberengo, from the Africa Centre for HIV/AIDS Management at Stellenbosch University. The results will contribute to the requirements of her MPhil degree. You were selected as a possible participant in this study because:

- You are 18 years and above.
- You are sexually active
- You live in Maruapula and you have been living here for the past 12 months.
- You are mentally competent to complete the questionnaire.

**1. PURPOSE OF THE STUDY**

The study seeks to establish whether there is a relationship between socio-economic status and the practice of safe sex among the residents of Maruapula.

**2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

- Read and understand everything about the study, i.e. the purpose of study, potential risks and discomforts, benefits, confidentiality, rights of participants etc.
- You will be asked to complete a questionnaire that will take between 15-20 minutes
- On the questionnaire, please mark with a X the given option that applies to you
- The questionnaire will be collected by me and it will be kept in such a manner as to guarantee your privacy.

**3. POTENTIAL RISKS AND DISCOMFORTS**

There are no known risks resulting from the study. However, there might be some discomforts. Discomforts anticipated in the proposed research are those ordinarily encountered when discussing about sex and sexual activity. If you require some more information or some form of counselling regarding discomforts, please do not hesitate to contact the researcher on +267 71494661 or her supervisor on +27 21 5554991

#### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

This research offers no direct benefits to participants. But, it might benefit the participants in understanding of HIV/AIDS prevention and contribute to their knowledge of available prevention programmes.

#### **5. PAYMENT FOR PARTICIPATION**

There will be no payment for participation in the research.

#### **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of questionnaires, notes and any other identifying participant information being kept in a locked file cabinet belonging to the researcher. After the research, all materials will be destroyed after 3 months. Information from the study will only be used for the purpose of this project. I request that participants should not use personal identifiable information in their responses to questions.

#### **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so

#### **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact Sarah Mberengo on +267 71494661, [sarahmude@yahoo.com](mailto:sarahmude@yahoo.com), Plot No. 7830 Maruapula. You can contact me on the above mobile number and email address at any time of the day. My project supervisor, Prof Elza Thomson can also be contacted on +27 21 5554991, email [elzathomson@gmail.com](mailto:elzathomson@gmail.com)

## 9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

### SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to [*me/the subject/the participant*] by [*name of relevant person*] in [*Afrikaans/English/Xhosa/other*] and [*I am/the subject is/the participant is*] in command of this language or it was satisfactorily translated to [*me/him/her*]. [*I/the participant/the subject*] was given the opportunity to ask questions and these questions were answered to [*my/his/her*] satisfaction.

Ke tlhaloseditswe kitsiso e e fa godimo ke Ruth Kelepang ka Setswana gape ke e ranoletswe ka fa go kgotsofatsang. Ke ne ka fiwa le sebaka sa go botsa dipotso tse di neng tsa arabiwa ka botlalo.

[*I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.*] I have been given a copy of this form.

Ke ithaopa go tsaya karolo mo dipatlisisong tse ebile ke filwe le pampiri ya dipotso.

---

**Name of Subject/Participant**

Leina la yo o arabang / motsaya karolo

---

**Name of Legal Representative (if applicable)**

---

**Signature of Subject/Participant or Legal Representative**

**Date**

Monwana wa yo o arabang dipotso/ motsaya karolo

Letsatsi

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_  
[*name of the subject/participant*] and/or [his/her] representative \_\_\_\_\_  
[*name of the representative*]. [*He/she*] was encouraged and given ample time to ask me  
any questions. This conversation was conducted in [*English/Setswana*] and [*no translator*  
*was used/this conversation was translated into Setswana by Ruth Kelepang*].

**Signature of Investigator**

**Date June 18, 2012**





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1	How old are you?	YEARS OLD	
		DOES NOT KNOW	
2	What is the highest level of school you attended?	NONE	
		PRIMARY	
		SECONDARY	
		POST-SECONDARY	
		OTHER, SPECIFY	
3	What is your marital status now?	SINGLE	
		MARRIED	
		LIVING IN UNION	
		WIDOWED	
		DIVORCED	
		SEPARATED	
4	Have you been employed in the last 12 months?	NO	
		YES	
5	How much did you earn a month including benefits?	1-500 PULA.	
		501-1000 PULA	
		1001-2000 PULA	
		2001-5000 PULA	
		5001-10000 PULA	
		10000-20000 PULA	
	20000 OR MORE PULA		

6	How many people depend on your income?	NONE	
		1 PERSON	
		2 PEOPLE	
		3 PEOPLE	
		4 PEOPLE	
		5 PEOPLE OR MORE	
7	Do you own a television that currently works?	YES	
		NO	
8	What do you use for cooking and lighting?	ELECTRICITY FOR BOTH	
		GAS FOR COOKING AND	
		ELECTRICITY	
		PARAFFIN FOR COOKING AND	
		CANDLES	
		FIREWOOD FOR COOKING	
9	How would you describe your economic position?	AND CANDLES	
		VERY GOOD	
		GOOD	
		REASONABLE	
		BAD	
		VERY BAD	
	Do you own a car?	NO	

<b>10</b>		YES	
<b>11</b>	Have you ever heard of HIV/AIDS	NO	
		YES	
<b>12</b>	What causes HIV/AIDS	WITCHCRAFT	
		VIRUS	
		PROSTITUTION	
		NOT USING A CONDOM	
		I DON'T KNOW	
		OTHER	
<b>13</b>	Do you know if there is anything a person can do to avoid getting AIDS?	NO	
		YES	
		DON'T KNOW	
<b>14</b>	During the past <u>three</u> months have you heard or seen anything on the radio, television or newspaper about HIV/AIDS prevention	NO	
		YES	
<b>15</b>	Tick all the places in the right column where you get or see information about HIV/AIDS	NOWHERE	
		GOVERNMENT	
		HEALTH CARE	
		WORKER (DOCTOR /NURSE)	
		PRIVATE HEALTH CARE	
		WORKER	
		(DOCTOR/NURSE )	
COMMUNITY HEALTH			
WORKER			
FAMILY PLANNING			
CLINIC PROVIDER			

		HUSBAND/WIFE (SPOUSE)	
		OTHER RELATIVES	
		FRIENDS	
		RADIO	
		TV	
16	Did you have sex in the last 12 months?	NO	
		YES	
17	Do you use a condom when having sex?	YES	
		NO	
18	Did you use a condom the last time you had sex?	YES	
		NO	
19	Do you have easy access to condoms?	YES	
		NO	
20	Do you consider yourself to be vulnerable to HIV infection?	YES	
		NO	
21	Do you know whether you are infected with HIV or not?	YES	
		NO	
22	Have you ever been tested for HIV?	YES	
		NO	
23	Do you want to know whether you are infected or not?	YES	
		NO	

<b>24</b>	How much do you think you are at risk of contracting HIV/AIDS? Would you say: no risk at all, medium risk or high risk?	NO RISK AT ALL	
		MEDIUM RISK	
		HIGH RISK	
		DON'T KNOW	

*This is the end of the interview. If you have got any questions about the research do not hesitate to call me on the following number: 71494661 Thank you very much for taking time to participate in this study.*



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**Please use the following scale to respond to the statements**

**Tlhopha karabo e e tshwanetseng go ka araba dipotso tse di latelang**

**SA: Strongly Agree**

**Ke dumalana thata**

**A: Agree**

**Ke a dumalana**

**N: Neither Agrees nor Disagrees**

**Ke fa gare**

**D: Disagrees**

**Ga ke dumele**

**SD: Strongly Disagree**

**Ga ke dumele gotlhelele**

1. -----I do not discuss HIV with my partner, because we are better off without knowing  
Ga ke nke ke buisana le mokapelo wame ka seemo same sa mogare wa HIV ka ke bona go sa tlhokafale
2. -----Discussing HIV with my partner would make us drift apart  
Go buisana le mokapelo wame ka seemo same sa mogare wa HIV go ka re kagoganya
3. -----I would rather know of my partner's past sexual history  
Ke ka mpa ka itse ka kgolagano ya mokapelo wame ya tlhakanelo dikobo
4. -----I don't discuss my partner's sexual history because I trust him  
Ga ke buisane le mokapelo wame ka botshelo jwa gagwe jwa tlhakanelo dikobo ka gore ke a mo tshepa

5. -----I would not offend my partner by asking about their past sexual activities.  
Ga ke kake ka kgopisa mokapelo wame ka go mmotsa ka kgolagano ya gagwe e e fetileng ya tlhakanelo
6. -----There is no need to go for an HIV test because I am healthy and strong  
Ga go tlhokafale gore ke itlhatlhobe mogare wa HIV ka gore ke itekanetse
7. -----I would go for an HIV test if I knew where to go where it is private  
Ke ka ya go itlhatlhobela mogare wa HIV fela fa ke ka itse gore kwa ke yang go itlhatlhoba teng go sephiri
8. -----HIV tests are not accurate  
Maduo a HIV ga a boammaaruri
9. -----I am afraid of an a HIV test in case I find out that I'm HIV- positive  
Ke tshaba go itlhatlhobela mogare ka ke ka fitlhela ke na le one
10. -----Only people who have multiple sexual partners need to be tested for HIV  
Batho ba ba nang le bakapelo ba le bantsi ke bone fela ba tshwanetseng go ka itlhatlhobela mogare
11. -----I would like to know if I am HIV-positive  
Ke ka rata go itse gore a ke na le mogare
12. -----if tested and was found HIV-positive, no one would date me  
Ga gona yo o ka ratanang le nna fa ke ka itlhatlhoba ke bo ke fitlhela ke na le mogare
13. -----knowing that you are positive is important because you would avoid infecting others  
Go itse gore o na le mogare go botlhokwa ka jaana o tlaa ela tlhoko gore ga o tsenye ba bangwe mogare
14. -----If I go for HIV-testing, they ask personal information which I don't want to share with anyone  
Fa ke ya go itlhatlhobela mogare, ba botsa dipotso tse ke sa batleng go di abelana le ope

15. -----I would use a condom with my partner only if I didn't trust him  
Ke ka dirisa sekausu le mokapelo wame fela fa ke sa mo tshepe
16. -----Condoms are not readily available for free  
Dikausu di nna di le teng ebile di tsewa go sa duelwe
17. -----There are government provided condoms which one can only get at the clinic  
Go na le dikausu tse di abiwang ke goromente, tse di bonwang kwa dikokelwaneng
18. -----If I collect condoms from the clinic, people might think I'm promiscuous  
  
Fa ke tsaya dikausu kwa kokelwaneng, batho ba ka akanya gore ga ke itlhokomele
19. -----Even if I knew my potential partners' sexual history, that would not change our sexual behaviors  
Le fa ke ka itse ka botshelo jwa tlhakanelo dikobo jwa mokapelo wame, seo se ka se fetole boitshwaro jwa rona mo go tsa tlhakanelo dikobo
20. -----One should not drink before sex  
Motho ga a tshwanela go nwa bojalwa pele ga tlhakanelo dikobo
21. -----Drunken people are careless in their sexual encounters  
Batho ba ba noleng bojalwa ga ba kelotlhoko fa ba tlhakanela dikobo
22. -----I find my potential sexual partners at drinking places  
Ke kgona go bona batho ba ke ka tlhakanelang dikobo le bone kwa mafelong a dino tagi
23. -----Drinking and having sex go together  
Tlhakanelo dikobo le go nwa bojalwa di a tsamaelana
24. -----The nurses who test people for HIV are not friendly  
Baoki ba ba tlhatlhobelang batho mogare wa HIV ga ba na botsalano
25. -----Even if I test positive for HIV, I don't think there will be help available

Ga ke dumele gore go ka nna le thuso epe le fa ke ka itlathloba mme ga fitlhelwa ke na le mogare wa HIV

26. -----I would not go for HIV testing because I am a Christian  
Ke ka seka ka itlathlobela mogare wa HIV ka ke le Mokeresete
27. -----I found my sexual partner from church so I trust them  
Ke tshepa mokapelo wame ka jaana ke kopane le ene kwa kerekeng
28. -----I cannot negotiate using a condom with my partner because I do not know how to.  
Ga ke kgone go buisana le mokapelo wame ka tiriso ya sekausu ka jaana ga ke itse go ka dira jalo
29. -----If I insist on condom use my partner will dump me  
Mokapelo wame o ka ntlogela fa ke ka nna ke gatelela tiriso ya sekausu
30. -----Condom spoils the lovemaking process that is why I do not use them  
Ga ke dirise dikausu ka di senya monate wa tlhakanelo dikobo
31. -----There is too much talk of HIV/AIDS as if it is the only thing that kills  
Go buiwa thata ka mogare wa HIV/AIDS jaaka ekare ke one fela o bolayang
32. -----There are too many other worries so HIV is not on the top list of my priorities  
Go dilo tse dintsi tse di tshwenyang mme HIV e se yone ya ntlha
33. -----Instead of worrying about HIV/AIDS, government should worry about other things that concerns us like unemployment  
Goromente o tshwanetse a tshwenyega ka dilo di tshwana le letlhoko la ditiro eseng go tshwenyega ka mogare wa HIV/AIDS
34. -----It takes long to get HIV/AIDS testing because the queues are too long  
Go tsaya sebaka go ka itlathlobela mogare ka jaana go na le mela e meelele
35. -----I do not think I can get HIV because I have one sexual partner; HIV/AIDS affects gays, prostitutes and drug users.

Ga ke dumele gore ke ka tsenwa ke mogare wa HIV ka gonne ke na le mokapelo a le mongwe; HIV/AIDS e tsena batho ba ba ratanang ka bong bo le bongwe, ba ba gwebang ka mmele le ba ba dirisang ditagi