Abstract

ANDERSON, TRACY JOY. “An Odor in the Air”: An Examination of Stigma, Alert Fatigue and HIV Prevention for Young Adults in Gaborone, Botswana. (Under the direction of Dr. James Kiwanuka-Tondo.)

The aim of this thesis is to examine the HIV/AIDS beliefs and experiences of young adults in Gaborone, Botswana using dimensions from the Health Belief Model. Three focus groups were conducted with 21 participants, ages 18-23. Findings from focus groups suggest that HIV/AIDS campaigns are overly abundant in Botswana and that as a result, HIV/AIDS has become normalized and campaigns are no longer effective. Traditional beliefs are fading from the younger, modern generations, but risky behaviors, including promiscuity and inconsistent condom use, continue to spread HIV/AIDS. Furthermore, stigma beliefs are cited as a serious detriment to preventative behaviors and hinder open conversation in the community, which is necessary for campaign success. Findings from this study imply that future campaigns should incorporate the stories of people living with HIV/AIDS to end stigma beliefs and should trim repetitive prevention messages to reduce desensitization to the threat and risk of HIV/AIDS in Botswana.
“An Odor in the Air”: An Examination of Stigma, Alert Fatigue and HIV Prevention for Young Adults in Gaborone, Botswana

by
Tracy Joy Anderson

A thesis submitted to the Graduate Faculty of North Carolina State University in partial fulfillment of the requirements for the degree of Master of Science

Communication

Raleigh, North Carolina

2014

APPROVED BY:

_________________________________________  ______________________________________
Dr. David Berube                         Dr. Sarah Stein

______________________________________
Dr. James Kiwanuka-Tondo
Committee Chair
Dedication

This paper is dedicated to my family. To my inspiring parents, Dawn and Gordon Anderson, who taught me to be curious about the world and to love thy neighbor as thyself (Matthew 22:39). To Billie Jones and Jacquelyn Anderson, my sisters, for their unconditional companionship and rejuvenating joy.
Biography

Tracy Anderson was born on September 23, 1989 in Coldwater, Ohio and grew up in Charlotte, North Carolina. A leader throughout high school, Tracy received the “Order of the Patriot” award for her high level of participation in activities including two years leading the marching band as drum major. She also played French horn in wind ensemble and orchestra. Tracy maintained a keen interest in learning about other cultures and peoples, winning a city-wide essay contest with the British-American Business Council of Charlotte that sent her to England for a summer educational program before her senior year. After graduating from Independence High School in 2007, she attended NC State University in Raleigh, NC for her undergraduate degree. While there, she worked as the Community Assistant Coordinator, managing a student staff at a university dormitory, for over three years. In 2010, she lived in Gaborone, Botswana for a semester abroad, where she discovered a new academic and personal direction and purpose, working with HIV-positive children at a local hospital. Tracy received her Bachelor of Arts in English with a minor in zoology in December 2011.

In August 2012, Tracy began the Master of Science in Communication program at NC State University. As a graduate student, she worked as a teaching assistant, academic advisor, and taught COM 110, an undergraduate public speaking course.
Acknowledgements

I would like to thank my chair of advisory, Dr. James Kiwanuka-Tondo for his guidance, expertise, and support throughout the research and writing of this work. I am forever grateful for the opportunities you have provided, both abroad and at home, to grow in research and experience. In the study abroad programs to Botswana and Uganda, your leadership and gracious character contributed to a memorable and transformative graduate experience. Thanks to Dr. Sarah Stein and Dr. David Berube for their assistance and inspiring instruction. I would also like to thank Billy Kgosikwena and Kedumetse Itseng from the University of Botswana Centre for the Study of HIV & AIDS for their help with recruiting participants and providing a location for the focus groups. Finally, I would like to express my gratitude to my cohort at NC State University for their camaraderie and encouragement, which kept me afloat.
# Table of Contents

**Introduction** .......................................................................................................................... 1

Cultural and traditional values ................................................................................................. 2

Gender issues .............................................................................................................................. 5

Societal influences .................................................................................................................... 7

Antiretroviral therapy ............................................................................................................. 7

Stigma .......................................................................................................................................... 8

Condom controversy ................................................................................................................ 10

Transportation ........................................................................................................................... 11

Young Adults .......................................................................................................................... 12

Prevention campaigns ............................................................................................................ 14

Health Belief Model ................................................................................................................ 16

**Methods** ................................................................................................................................ 18

**Findings** .................................................................................................................................. 20

Experience ................................................................................................................................... 21

HIV/AIDS prevention campaigns ........................................................................................... 21

Oversaturation .......................................................................................................................... 25

Traditional beliefs and practices ............................................................................................. 27

Beliefs .......................................................................................................................................... 29

Perspectives about HIV/AIDS ................................................................................................. 29

Personal responsibility ............................................................................................................. 30

Antiretroviral therapy .............................................................................................................. 32
Introduction

Since its independence in 1966 and the discovery of diamonds in the early 1970s, Botswana has earned a reputation as being a success story among newly developed African countries. In 1965, Botswana was ranked as the third poorest nation in the world (Beaulier & Subrick, 2007). However, after a change in government and an influx of revenue from the diamond trade, “Botswana’s per capita income went from $372 in 1965 to $1032 in 1975” (Beaulier & Subrick, 2007, p. 54). Furthermore, the poverty ratio dropped from 59% in 1986 to 30.6% in 2003 (The World Bank, 2014). Public services expanded, as income generated from diamond exports was applied to education, health facilities, urban development, welfare services, and clean water access (Renwick, 2007). The growth has continued steadily and today, Botswana is considered to be an upper-middle income country, with a GNI per capita of $7,650 in 2012 (Beaulier & Subrick, 2007; The World Bank, 2014).

Despite its developmental progress, Botswana is heavily burdened with the societal, financial, and humanitarian effects of the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) epidemic. Although the rates of new infections have dropped 71% between 2001 and 2011, the virus and its corresponding disease continues to spread and disrupt the balance of life in Botswana. In 2012, there were about 12,000 new infections in Botswana and around 5,700 AIDS deaths (UNAIDS, 2013). The latest estimates showed that Botswana has a prevalence rate of 23% among adults ages 15-49, with around 340,000 people living with HIV (UNAIDS, 2013). These rates place Botswana with the third highest prevalence in the world, topped only by Swaziland and Lesotho (Central Intelligence Agency, 2014). In response to the high infection rates, a number of prevention
programs and campaigns have been implemented in Botswana, but the southern African nation still faces major obstacles with stigma, cultural practices, and social assumptions that hinder prevention efforts and further the spread of HIV/AIDS.

The purpose of the current study is to examine young adult experiences and beliefs relating to HIV/AIDS prevention in Gaborone, Botswana. Although there is a considerable amount of data and research on HIV/AIDS in Botswana from a variety of disciplines, there have been few studies that depict a qualitative perspective of modern young adults’ personal opinions, experiences, and reactions to HIV/AIDS prevention campaigns. Furthermore, no study has considered the repercussions that emerge from excessive prevention and risk messages about HIV/AIDS. This paper will first summarize previous research on the factors that affect the spread of HIV/AIDS in Botswana, including cultural values, traditional practices, and societal influences. This will be followed by an analysis of current prevention campaigns, which will utilize past research and the findings of the current study using the Health Belief Model. Lastly, this paper will offer suggestions for future prevention efforts.

**Cultural and Traditional Values**

A multitude of scholars have declared the need for culturally relevant HIV prevention campaigns (Green & Ruark, 2011; Rodlach, 2006). According to Rogers & Storey (1987), “campaign appeals that are socially distant from the audience member are not effective” (p. 838). Furthermore, breaking a social standard with no regard for the emotional response is an ineffective strategy and may be taken as a sign of disrespect and misunderstanding of the culture involved. To effectively interest, educate, and influence a behavior of a particular
society, a campaign needs to appeal to the interests and values of the target audience. To successfully create behavior change and promote an environment of open communication and information, HIV/AIDS prevention campaigns in Botswana should appeal to culturally valued topics to persuade people to be active about their HIV status. To transform the future of HIV/AIDS prevention in Botswana, it is important to understand the underlying cultural and traditional values that influence sexual behavior and decision making. For instance, in Botswana culture, having children early in life is considered to be advantageous for anyone who desires to get married and start a family. To verify personal fertility and attempt to attract potential future husbands, a young woman may become pregnant before marriage or a man may seek to get a woman pregnant (MacDonald, 1996). “Single women know that if they are barren they are likely to be divorced and that they can avoid this humiliation by having a child prior to marriage” (MacDonald, 1996, p. 1329). The pressure to bear children also affects men. “Hegemonic constructions of masculinities are intimately related to sexual prowess such that the biological fathering of children is a vital marker of male virility and masculinity” (Datta, 2007, p. 98). Contraceptive use and safe sexual practices are often abandoned in these pursuits of proving fertility and having children.

In one study it was found that “fears of sterility overshadow fears of HIV/AIDS to the extent that the majority of individuals interviewed reported that they would engage in risky sexual behaviors and practices despite their high levels of education and knowledge on the epidemic” (Upton & Dolan, 2011, p. 97). Childbirth is believed to “cleanse a woman’s womb, therefore a woman who does not have many children is unclean” (MacDonald, 1996, p. 1329). It is also believed, among some people in Botswana, that having sex with a virgin
or a young girl can cure a person of HIV/AIDS or cleanse the reproductive system (Bene & Darkoh, 2012; Ntseane, 2004). In many cases, “risky behaviors are driven out of a need to fulfill cultural norms and gendered expectations about personhood, reproduction, and identity” (Upton & Dolan, 2011, p. 96).

The majority of the population of Botswana is spread out in the rural areas (Barbee, 1986). As a result of this, many villages and cattle post areas do not have consistent access to modern medical clinics or certified medical doctors. In 1994, the ratio of medical doctors to the population in sub-Saharan Africa was 1/40,000 while the ratio of traditional healers to the population was 1/500 (Abdool, Ziqubu-Page, & Arendse, 1994). Without access to modern clinics or doctors, many people turn to traditional medicine, sometimes referred to as ethno-medicine, performed by traditional specialists (*dingaka*) or spiritual healers (*dingaka tsa metse*) (Barbee, 1986). Usage of traditional medicine has been widely viewed as an impediment to HIV/AIDS prevention (Simmons, 2009). In 1997, when Botswana had the highest rate of HIV in the world, many traditional doctors were ill-informed about the virus and around 60% of participants involved in traditional medicine did not know what causes HIV (Chipfakacha, 1997). Nonetheless, ethnomedicine has been in demand in Botswana. One study done in 2003 found that 47% of patients had pursued traditional medicine for HIV infection, but 92% preferred modern medicines (Weiser et al., 2003). In 2013, nearly 15% of the circumcisions in Botswana were done using traditional methods (Statistics Botswana & National AIDS Coordinating Agency, 2013).

Though controversial, traditional medicine is a consequential part of Botswana culture and must not be left out in the planning and implementation of HIV/AIDS prevention
strategies. Previous HIV prevention campaigns that did not involve cooperation or acknowledgment of traditional medicine and deeply rooted cultural beliefs did not successfully enter the public sphere. It has been argued that the failure of past HIV prevention campaigns in Botswana may be due to the alienation of cultural chiefs (Kiwanuka-Tondo et al., 2013). The government of Botswana has recognized the relevance of these cultural practices and since 1980 has sought to “promote collaboration and cooperation between traditional healers and the formal health sector” (Chipfakacha, 1997).

**Gender issues.** Cultural ideas of gender and power have been shown to shape the decision making process involving safe sexual behaviors and the ability of women to protect themselves in Botswana. According to the Botswana AIDS Impact Survey done in 2013 (BAIS IV), women are disproportionately infected, with higher prevalence rates (19.2%) than men (14.1%) across all educational backgrounds and living situations (Statistics Botswana & National AIDS Coordinating Agency, 2013). In most cases, females are not able to negotiate or insist on condom use or other safe sexual practices in a relationship or sexual encounter (Seloilwe et al., 2001). “The lack of control over key areas of sexual decision making, the economic dependence on men, the limitations of their capacity to influence male behavior and the prevalence of coercive intercourse means that women in these rural villages are poorly placed to negotiate their own or their partner’s safe sexual health” (Bene & Darkoh, 2012, p. 20). One study found that “being female and working in a relatively low status of employment were associated with increased likelihood of HIV infection” and that females reach a high peak of HIV risk ten years before their male counterparts (Kandala et al., 2012,
It is important to note that women are also disproportionately affected at a young age. Girls ages 15-19 are three times more likely to be infected than boys of the same age (UNAIDS, 2012a).

Social ideals and assumptions about sex and gender may also facilitate high infection rates. Some people in Botswana believe that men who have multiple sexual partners are macho (Ntseane, 2004). Married women who are not able to insist on condom use with a promiscuous husband are at a high risk of HIV infection. “In Botswana, women may not be constrained by lack of knowledge about HIV/AIDS or the accessibility of condoms, but they may still submit to a partner who may have multiple partners and who is unwilling to use a condom” (Greig & Koopman, 2003, p. 196). Economic independence is the most strongly related factor for women to negotiate safe sex (Greig & Koopman, 2003). “These results suggest that women who are economically independent may find it more acceptable to negotiate for safe sex while facing the risk of losing actual or potential support from their male partners” (Greig & Koopman, 2003, p. 205).

Extreme poverty and unemployment forces some women to become commercial sex workers to survive (Ntseane, 2004). “Since clients of sex workers are mostly married men who do not like to use condoms, HIV/AIDS prevention will continue to be a big challenge in this region” (Ntseane, 2004, p.13). The face of commercial sex workers is also changing, as economic opportunities for women are scarce. “In poverty situations like the one seen in Southern Africa a sex worker is no longer the traditional conservative illiterate young girl who hangs around the bars; she could actually be an educated, unemployed or working woman who needs to supplement her meagre salary” (Ntseane, 2004, p. 15).
Societal Influences

**Antiretroviral therapy.** In 2002, “Botswana was the first African country to implement a free national antiretroviral therapy (ART) programme” (UNAIDS, 2012a, p. 37). Removing the financial burden of a costly treatment for those living with HIV has greatly reduced the number of AIDS deaths per year in Botswana. As one report disclosed, “the provision of ART has averted an estimated 53,000 deaths from 2000 to 2007” (Stover et al., 2008, p. 3). ARV therapy can reduce transmission of HIV among people living with HIV/AIDS (PLWHA) and greatly reduces the risk of sexual transmission of HIV between serodiscordant couples (UNAIDS, 2012b). Thus far, the ARV therapy program in Botswana has provided treatment for the majority of citizens that need it. A recent report revealed that around 95% of people eligible for treatment had access to antiretrovirals in Botswana, from 194 clinics nationwide (UNAIDS, 2012a).

Public access to free antiretroviral treatment has greatly reduced the number of deaths from AIDS and the suffering of those living positively. However, if there is no behavior change, “the risk of creating an ever-increasing demand for drugs, later impossible to satisfy, has to be specifically considered” (Hanson, 2005, p. 234). The demands for these drugs are creating an ever-increasing expense for the entire country. The government of Botswana has been able to provide ARV therapy treatment free of charge to most of its citizens (Allen & Heald, 2004). However, the country relies heavily on public and private western donations to fund those treatments and the funding arrangements set in place are not permanent (Allen & Heald, 2004). According to Stover et al. (2008), about 23,000 adults per year develop the need for ARV therapy (p. 3). “The need for ART is expected to increase by almost 60%
from 120,000 in 2007 to about 190,000 by 2016 if the high levels of coverage are maintained” (Stover et al., 2008, p. 3). The government of Botswana will not be able to keep providing free treatment if these numbers continue to rise. Botswana’s economic and societal success may also affect the flow of donor funding for HIV programs. “Assuming that it is a country which can now fend for itself economically has seen international donors withdraw, the financial burden upon the state increasing considerably, other disease treatment restricted and infrastructural development projects deferred” (Renwick, 2007, p. 153). Along with a large demand for the expensive treatment, some scholars are worried that the successes of ARV therapy treatment may contribute to a rise in complacency to HIV infection (Cohen, 2008).

**Stigma.** One of the biggest social obstacles for sexual behavior change in Botswana is the stigma that envelops HIV/AIDS and prevents informed people from taking steps to protect themselves. “The fear of being identified as HIV-positive prevents people from learning their sero-status, changing unsafe sexual behaviors and caring for people living with HIV and AIDS” (UNAIDS, 2012a, p. 19). People living with HIV in Botswana face discrimination and often isolation in the community. Preliminary results from the BAIS VI show that only 23% of the population expressed all of the listed accepting attitudes towards people living with HIV/AIDS (PLWHA) (Statistics Botswana & National AIDS Coordinating Agency, 2013). “Most people associated AIDS with death and social stigma and preferred to rather keep quiet or deny about their status” (Bene & Darkoh, 2012, p. 20). One study found that “69% of patients kept their HIV status a secret from their families, and 94% kept their status a secret from people in their community” (Weiser et al., 2003, p. 285).
Research has shown that access to ARV therapy may shrink stigma in some areas. As one study showed, “Sixty-three percent of respondents said that the increasing availability of antiretrovirals in Botswana has led to a reduction of discrimination toward people living with HIV/AIDS” (Wolfe et al., 2008, p. 1867). Another study examined the community perceptions about stigma relating to HIV/AIDS and found that overall, HIV stigma has been reduced since the universal ART program was started in 2002, but respondents still held stigmatizing attitudes and highly anticipated experiencing stigma in the event of infection (Wolfe et al., 2008). Fifty-three percent of respondents answered that if they were HIV-positive, they believed the community would treat them like an outcast, around 40% said that they would lose friends, and around 30% expected to be treated badly at work or school (Wolfe et al., 2008). Around 27% of the same participants also held stigmatized beliefs and answered that they would not be willing to share a meal with a person who was HIV-positive (Wolfe et al., 2008). In the study, “perceived access to treatment was the strongest protective factor both against holding stigmatizing attitudes toward others and against anticipating HIV stigma toward oneself” (Wolfe et al., 2008, p. 1870).

According to Kotler & Andreasen (1991), campaigns should make a determined effort to understand the cultural context of a social problem and seek to change the climate of society to welcome and encourage individual behavior change. Currently, stigma involving HIV/AIDS prevents a social climate in Botswana that welcomes change. Stigma and attitudes must be considered as some of the most influential social dynamics that lead to the spread of HIV/AIDS. Without an understanding of these dynamics, communication models from developed areas “often have little or no impact upon the peoples for whom they are intended.
because they are not contextualized against local settings and are often ignorant of cultural dynamics and worldviews” (Nabulime & McEwan, 2011, p. 278).

Condom controversy. According to the Botswana AIDS Impact Study (BAIS) study from 2008, condom use among respondents is inconsistent (Republic of Botswana et al., 2009). While 55% of respondents reported using a condom during the first sexual contact with their most recent partners, only 27.7% of respondents reported that they always use condoms with regular sexual partners (Republic of Botswana et al., 2009). A study done with commercial sex workers in Botswana found that “condoms are used in less than 10 per cent of these sexual encounters because most clients do not like condoms” (Ntseane, 2004, p. 13). In another study, 46% of respondents claimed that lack of condoms was one of the most common drivers of HIV/AIDS in Botswana (Bene & Darkoh, 2012).

In the early prevention campaigns launched in Botswana, pushing condom use onto a society that did not support open conversation about sex was detrimental because the community was not prepared for such candid advertising. In fact, when the HIV prevention campaigns in Botswana first praised the use of condoms to protect oneself against HIV, many church groups, local healers, parents, and chiefs were in strong opposition (Allen & Heald, 2004). For years, rumors and misinformation led to widespread distrust of the condom. One rumor alleged that condoms could kill a woman if they got stuck inside of her (Allen & Heald, 2004). Another belief was that condoms actually spread AIDS. “This belief was reinforced by the fact that when a condom is put in warm water, the lubricant produces worm-like particles, which some believe are HIV viruses” (Brown et al., 2008, p. 322). A
study done in rural areas of Botswana found that respondents “did not use condoms because they felt condoms were made for white people” (Bene & Darkoh, 2012, p. 15).

A number of societal pressures may lead to unprotected sex. A study that focused on sexual behaviors of students at the University of Botswana found that 16% of respondents reported that condom use was abandoned as a result of trusting one’s partner (Stephens et al., 2012). Twenty-seven percent of participants also cited alcohol and drug use as reasons for not using a condom (Stephens et al., 2012). Those that use condoms do to prevent pregnancy as well as HIV. In fact, in one study, the fear of catching AIDS only accounted for 57% of condom use, while 43% of respondents reported that they use condoms to avoid pregnancy (Bene & Darkoh, 2012, p. 17).

**Transportation.** Major infrastructural development in Botswana has led to easier and more accessible transportation. As a result of more paved roads and affordable cars, many people work and live in the city during the week and travel home to their rural villages for the weekend (Cohen, 2008). This has led to a transformation of the typical social networks in the community and an increase in connectivity between rural and urban areas. Unfortunately, this mobile lifestyle often leads to promiscuity and multiple sexual relationships with different partners across the country (Cohen, 2008). “Botswana is also a corridor for goods transported by road or rail from South Africa to Zambia, the Democratic Republic of Congo, Angola, and Malawi, as well as from Namibia to its eastern neighbors” (Barnett & Whiteside, 1999, p. 218). Transportation from the cities and between neighboring countries has sometimes been partnered with the spread of AIDS. Chiefs in rural parts of
Botswana have even declared that “HIV was an external problem, with people who had been working in the town coming back to die” (Allen & Heald, 2004, p. 1147). With modern transportation, city employment, and changing family environments, extramarital affairs and casual sex are increasingly common among men and women (Susser & Stein, 2000, p. 1043). The promiscuous social environment is a breeding zone and catalyst for the spread of HIV and AIDS.

**Young Adults**

Young adults in Botswana straddle a unique partition of standards, between the traditional practices and beliefs of a historically culture-rich nation and the evolving modern communities in the urban areas. Since many people experience sexual debut in the teenage and young adult years, it is important to reach this age group with HIV prevention campaigns. A study done with sero-prevalent mothers in 2006 found that “about 55% of the total population was initiated to sexual intercourse by age 19 and around 8% have had sex by age 15” (UNAIDS, 2012a, p. 18). Another study done in 2001 found that most students had engaged in penetrative sex between 12 and 14 years and 94% of students had experienced sex by the age of 23 (Seloilwe et al., 2001). The BAIS III supported these statistics, reporting that 85.6% of respondents had engaged in sexual intercourse by age 24 (Republic of Botswana et al., 2009). According to the most recent BAIS, the percentage of young women and men who have engaged in sexual intercourse before the age of 15 has actually increased in the last four years, going from 3.5% in 2008 to 4.6% in 2013 (Statistics Botswana & National AIDS Coordinating Agency, 2013).
Many people in Botswana move during young adulthood from their home village to city areas like Gaborone, the capital of Botswana, where there are more educational and economic opportunities. In fact, most young adults live in the urban areas of Botswana (Republic of Botswana et al., 2009). “Poverty in the rural areas of Botswana is pushing young people to move to urban areas where they hope to get employment” (Ntseane, 2004). One study examined the attitudes and behaviors of students that attend the University of Botswana (located in Gaborone) and found that in transition from a village atmosphere, many young adults experience that “easy access to sex and alcohol, great peer pressure, and lack of money combined to encourage HIV/AIDS risky behavior” (Brown et al., 2008, p. 320). On the university campus, “it is common for young women to engage in sexual relations with older men from off campus. There is a great peer pressure to have the “Five Cs,” that is cash, cars, clothing, cell phones, and celebrity. One way to get those things is from an older man with more money, and young women are willing to obtain the Five Cs in exchange for a sexual relationship” (Brown et al., 2008, p. 320). In these intergenerational relationships, young women often have little to no negotiation power with the use of contraceptives during sex.

Young adults in Botswana have experience and access to modern technology, which dispenses a great deal of information about HIV/AIDS. Despite the improved capabilities for the diffusion of information, many young people are poorly educated about HIV/AIDS. According to the BAIS completed in 2008, only 54.4% of people ages 15-19 and 53.9% of people ages 20-24 could deny common misconceptions about HIV/AIDS, including the belief that it could be spread through witchcraft or mosquito bites (Republic of Botswana,
Central Statistics Office, and National AIDS Coordinating Agency, 2009). Twenty-nine percent of respondents in a study published by Bene and Darkoh (2012) in rural areas of Botswana claimed that ignorance about HIV/AIDS was one of the most common drivers of the epidemic. Another study from the University of Botswana partially contradicted this finding and found that “students have factual knowledge and information about HIV/AIDS, but their actual sexual practices and behavior do not reflect this high level of knowledge,” as “students engage in risky sexual behavior including sexual experience in early youth, unprotected sex, casual and multiple partners” (Seloilwe et al., 2001, p. 204).

Although young adults are surrounded with HIV/AIDS prevention campaigns and information, previous research has shown that to some extent, students and young people still feel distanced from HIV/AIDS. As one report stated, “They explained that because they had never known nor heard of anyone their age who had AIDS, it did not seem ‘real’ to them, and they believed AIDS was ‘not our disease’” (Brown et al., 2008, p. 324). Further, while many recognized the importance of testing for HIV, only half of participants in one study believed that HIV testing was practiced among peers (Stephens et al., 2012).

Prevention Campaigns

Since the swell of infections in the 1980s, a number of prevention efforts have attempted to stop the spread of HIV/AIDS in Botswana. Initial prevention campaigns launched in Botswana in 1988 and included bumper stickers, T shirts, radio messages and billboards proclaiming the ABC method (which encouraged people to Abstain, Be Faithful, or Condomize) (Allen & Heald, 2004). The early advertisements were considered to be
largely ineffective and socially distant to the people of Botswana. Rather than utilizing local languages, the promotions were printed in English, and blatantly ignored the community’s attitudes and opinions regarding discussions about sex (Allen & Heald, 2004). “In Botswana there is a deep-seated unwillingness to talk openly about sex, partly due to rules of respect that lie at the heart of family and kinship structures” (Allen & Heald, 2004, p. 1144). The giant posters and billboards of the time openly and boldly discussed a topic that was considered to be taboo and embarrassed the local community members. At the time of their debut in the 1980s, the ABC prevention messages were introduced coldly into a community environment that was not prepared for an open discussion about sexual matters.

The initial prevention campaigns also excluded the involvement of some of the most respected members of Botswana culture. “The governments’ following of an exclusively western model fuelled suspicion, which the exclusion of diviners, healers, and churchmen from the campaigns did nothing to ameliorate” (Allen & Heald, 2004, p. 1144). The early campaigns did not respect cultural values and were not introduced in accordance with the normal authority figures. The prevention of HIV infection in Botswana is an intricate and complicated task. Campaigns promoting behavior change that lead to the prevention of some invisible, distant consequence are often the most difficult to carry out with success. “The nature of preventive ideas means that rewards for their adoption and use are often delayed, uncertain, and weak ; the locus of benefit may not be clearly perceived to be oneself” (Rogers & Storey, 1987, p. 839). While many people in Botswana seem educated about HIV/AIDS and have been exposed to the effects of the epidemic, the risk messages seem to be lost on the audience. Participants in one study “stated that people knew very well about
the disease but they had an innate mentality that it would not happen to them” (Bene & Darkoh, 2012, p.15).

A select few of the prevention efforts in Botswana have experienced success in the community. Governmental programs for the prevention of mother-to-child transmission (PMTCT) started in 1999 (UNAIDS, 2012a). Since then, the PMTCT program has brought the average rate of mother-to-child transmission down to 3.7% (Stover et al., 2008). “The expansion of the PMTCT program has averted 10,000 child infections from 2002 to 2007” and “nearly 11,000 child deaths have been averted by the combined effects of PMTCT, child treatment, and adult ART” (Stover et al., 2008, p.3). According to a report by UNAIDS (2012a), the number of infections occurring with children younger than 15 years old has declined 78% from 2001-2009. These numbers show that strategic governmental programs used in cooperation with medical facilities can be very successful.

**Health Belief Model**

The Health Belief Model (HBM) has been utilized for many years as a framework to analyze health behavioral decisions, especially in relation to the prevention of disease or illness (Donadiki et al., 2014; D’Souza et al., 2011; Galvin, 1992; Kim, Ahn, & No, 2012; Solhi et al., 2010; Thalacker, 2001). The HBM is “a value-expectancy theory that attempts to describe the valuation of the desire to avoid illness (or treat it effectively) and the types of expectations about health that are essential in influencing preventative (or self-care) behavior” (Clemow, 2004, p. 390). In regards to health decisions, behaviors are dependent on “(1) the desire to avoid illness (or if ill, to get well); and (2) the belief that a specific
health action will prevent (or ameliorate) illness” (Janz & Becker, 1984, p. 2). The HBM considers six dimensions, including perceived threat, perceived benefits, perceived barriers, cues to action, other modifying variables, and self-efficacy (Clemow, 2004). “The HBM proposes that when individuals see a threatening disease and how they can benefit by taking preventative action, then that individual is likely to take action” (D’Souza et al., 2011, p.138). In these situations, beliefs and situations work together to encourage the adoption of a health behavior.

An examination of multiple studies’ findings utilizing the HBM found that the dimension of barriers was the most significantly associated with behaviors (91%), followed closely by benefits (81%) (Janz & Becker, 1984). One study conducted with college students in the United States found that “a high level of Benefit and a low level of Barrier about eating health food will lead to positive Behavioral Intentions to eat healthy food and do physical activity” (Kim, Ahn, & No, 2012, p. 556). The same study found that “susceptibility and severity were not significant predictors of Behavioral Intentions for college students,” which may be due to the fact that chronic diseases like diabetes and obesity are not common among young people (Kim et al., 2012, p. 556).

The following research questions guided this study:

1. What HIV/AIDS prevention campaigns have the participants seen and heard?
2. How do participants respond to the prevention campaigns that they encounter?
3. What societal influences on young adults affect HIV prevention behaviors among young adults in Botswana?
4. What traditional and cultural beliefs influence HIV prevention behaviors among young adults in Botswana?

**Methods**

The current study examines young adult experiences and beliefs relating to HIV/AIDS prevention in Gaborone, Botswana. To stop the spread of HIV infection, it is necessary to understand the societal and cultural conditions that young adults experience which may influence their decisions to perform preventative behaviors. Open-ended, comprehensive conversations about personal beliefs and experiences will shed light on issues that may have been previously overlooked in quantitative studies and surveys (Majelantle et al., 2014; Onyewadume, 2008; Ray & Sinha, 2012). The dimensions of the HBM require a thorough understanding of the perceived threats, barriers, benefits, and cues involved with prevention behaviors. It is essential to document and consider the changing social values, pressures, fears, hopes, and experiences of the young adults as technology infiltrates daily life and the community of Botswana rapidly changes with modernization. The current study sought to provide young adults with a chance to express their personal thoughts and opinions about HIV prevention while reporting on campaigns they have seen and heard.

Information was collected through three focus groups held at the University of Botswana with a total of 21 young adults. Having an open-ended and candid discussion in the form of a focus group is appropriate for this particular study because participants are able to express thoughts and opinions without being limited to pre-selected, quantifiable responses. In an open and flexible discussion, participants are able to react to one another’s
responses and guide the conversation to topics that are relevant and previously unknown. The nonverbal feedback from the participants also helps the researcher to understand the emotions and natural reactions to HIV prevention campaigns.

Participants were recruited through the University of Botswana Centre for the Study of HIV & AIDS and ranged in ages from 18-23, with an average age of 19.3 years old. The majority (66.7%) of the participants were female. Most of the participants were born in Botswana, but one was originally from the neighboring country of Namibia. Recruitment for this study was completed through the Center for HIV/AIDS Research (CHAR) at the University of Botswana. Some of the participants were contacted because of previous participation in other studies about HIV/AIDS.

This study focused on young adults that dwell in Gaborone, the capital city of Botswana. Many prevention campaigns can be found in the highly developed areas of Botswana, so this particular group is able to provide good insight on the relative successes and failures of campaigns that seek to reach the young adult target group. Since many young adults in Botswana live in urban areas, the participants were recruited in the capital city of Gaborone, and should provide an accurate depiction of young adult opinions and experiences (Republic of Botswana et al., 2009).

After providing informed consent, each participant completed a paper-and-pencil questionnaire that inquired about their personal values, beliefs, fears, and experiences with traditional practices and to allow the participants to report anonymously their opinions and reactions to HIV/AIDS prevention campaigns. Upon completion of the questionnaire, the researcher initiated a group discussion using a semi-structured interview format. Each focus
group involved six to eight participants and lasted for about two hours. Participants were asked a series of open-ended questions about their opinions, beliefs, and experiences related to HIV prevention campaigns, testing centers, education, family conversations, and community values. Participants received a small monetary gift for their participation in the study.

Focus groups were audio recorded and transcribed verbatim. The transcripts from the focus group were coded for relevant and recurring themes and analyzed using the grounded theory method. After several cycles of coding, the data was narrowed down to responses that either represented a repeated and significant thought from the group or described an interesting new phenomenon that has not been reported yet.

**Findings**

Transcripts from the focus groups were reviewed and a collection of relevant themes surfaced, comprised of three broad categories including personal experience, beliefs, and stigma. To chronicle personal experiences, participants recounted HIV/AIDS prevention campaigns they had seen or heard and the corresponding public and personal responses to those messages. Perceptions and experiences with traditional and cultural practices were also discussed. Beliefs about HIV/AIDS were illustrated through conversation about antiretroviral therapy programs, perceived access to information, individual perspectives about sexual behavior, and the importance of personal responsibility in sexual health.
Stigmatic beliefs in the community were a prominent theme throughout the discussion, with specific detail given to condom use and conversations about HIV/AIDS.

**Experience**

**HIV/AIDS prevention campaigns.** The focus groups each began with a conversation about individual experiences with HIV/AIDS prevention campaigns in community areas, schools, homes, and via mass media. All 21 participants were taught about HIV/AIDS in school, with the majority having learned about HIV/AIDS in primary school. Lessons about family planning were said to be routinely covered in school. However, participants expressed dissatisfaction with the scope and practicality of the information provided and there was an apparent discrepancy between participants’ experiences. Some members were given hands-on sex education, with condom demonstrations and functional activities, while others received only a trivial textbook lesson about HIV/AIDS.

*In schools, yes, they do teach, but they don’t also demonstrate to us. They can teach us about assertive communication, but then let’s practice it. So I think they give us information and we don’t know what to do with that information at the end of the day.*

Participants were familiar with many of the prominent campaigns featured in public areas in the community, including the PMTCT program (Prevention of Mother to Child Transmission), the Safe Male Circumcision program, and the ABC campaign (Abstain, Be
Television programs were frequently mentioned, including InterSEXtions\(^1\), Mareledi\(^2\), and another underreported show. Many participants expressed a dislike for programs produced by Botswana Television Network (BTV). As one participant said, “In Botswana, we have this thing I guess with BTV. I don’t know, it’s like we hate it. We think it’s boring.” Another said that BTV mishandles HIV/AIDS as an entertainment tool. “Most of the shows that have been made locally have never been about entertaining, it’s always just been about HIV. To sensitize. I’m not entirely happy.” Despite the perceived lack of quality in BTV productions, the majority of participants said that they watched these programs. Participants also noted that the dramatization of HIV through television shows may warp people’s perceptions about the virus.

_These TV shows that we’ve seen, these dramas, most of the time people who are infected—they end up dying. So what are we saying to the public? That when you get AIDS, you end up dying._

_We’ve seen a lot of advertisements that bring AIDS to be this horrific thing._

_They even sometimes show horrific things about HIV. They don’t actually_

---

\(^1\) TV drama series produced by South African Broadcast Corporation (SABC1) which explores topics including HIV/AIDS, love, sex, and relationships.

\(^2\) Botswana Television (BTV) drama which “aims to sensitize people on issues relating to HIV/AIDS” (Motsumi, 2013). Funded by National AIDS Coordinating Agency (NACA) and produced by Makgabaneng (serial radio drama).
have the topic to learn more about HIV. Instead, what they do, they make people afraid of HIV instead of learning about HIV and seeing what they can do about it.

Participants also indicated that they had seen a variety of HIV prevention billboards, featuring messages which discourage the practice of multiple concurrent sexual partners, encourage the use of condoms, and remonstrate alcohol use in relation to safe sex. The young adults also referred to the O Icheke—Break the Chain campaign\(^1\) and messages that empower women to take control of their personal health. However, these messages were seen as largely ineffective because the social environment of Botswana does not correlate with some of the prevention messages.

When it comes to alcohol, just...putting a billboard to Botswana that says ‘Don’t drink it will lead to such things’—it’s sort of like a waste of money. On a very serious note. Why? Cause, in Botswana there isn’t much entertainment. So people tend to use alcohol, so generally it won’t help, because alcohol is the main source of entertainment for Botswana. And there’s a lot of alcohol.

\(^1\) O Icheke means “check yourself” in Setswana. The campaign includes radio, television, and print messages that emphasize the acceleration of the spread of HIV through multiple concurrent partners.
While there was a great quantity of HIV prevention messages considered in the focus groups, participants frequently complained about the quality and effectiveness of the messages. Some of the participants expressed that they felt as if none of the campaigns were working. “If at all they were effective, we wouldn’t have a high population of people who are infected.” One participant declared that she felt the billboards are just for decoration. Others cited the apparent lack of practical detail in many of the messages.

They just tell people to use condoms. And they’re not saying which condoms to use. I mean if I get into a store then maybe see condoms there...there’s like the latex condom, the polyurethane condom, and the natural skin condom. So it’s not really helping that much.

Well I think they don’t work because they just give us the information then they don’t show us how to go out and make use of the information. Well ok, use a female condom. We don’t even know how to use a female condom. We’re supposed to use it and we don’t even know how to use it.

Although they were familiar with many of the campaign efforts, overall, the participants did not seem hopeful about the outcome or impact of the various campaigns.

People continue to have unprotected sex. People continue to do all the things that we’re told not to do because you’re not in the situation, we keep thinking
that it will happen to so and so but it won’t happen to you. Nothing is really effective, to me.

Another participant stated that prevention messages are futile without personal experience with HIV/AIDS.

I don’t think anything is effective, in my opinion, unless you are in the situation or know somebody that is close to you that is infected. That’s the only way that you can actually begin to comprehend what is really happening.

**Oversaturation.** Throughout the discussion about HIV/AIDS prevention campaigns, participants repeatedly indicated that HIV/AIDS is discussed so frequently in advertisements, programs, and broadcasts that they feel oversaturated with prevention messages.

I think these advertisements about AIDS—I think it is now a cliché. I think people have heard about AIDS a lot, have seen it, but it’s everywhere. So people just ignore it these days. Even if there’s new information, you hear something about AIDS and you say ‘Ugh, it’s AIDS.’ It’s now just full to the brim, so people just ignore it. It’s like, it’s now a normal thing these days.

People don’t care that much about AIDS.
The participants said that they hear about HIV/AIDS so frequently that they are almost numb to the messages and quite often ignore them altogether. A participant explained by saying, “It’s just so normal. Every day you do hear something about AIDS, so we just tend to go ahh, I don’t want to talk about AIDS.” Another participant added that, “I think AIDS has been talked about too much. I think we’re saturated with information, but like I said, until it affects you, it’s whatever.” Others noted that the abundance of conversation about HIV/AIDS has taken away from the severity of the virus.

I think the biggest problem is also that we have normalized AIDS. It’s no longer something that is grave. Because we talk about it more than we talk about cancer and other diseases. It’s just normal.

The prevailing opinion in the focus groups was that the abundance of prevention campaigns around Botswana has desensitized young people in the community to HIV/AIDS. Even so, participants felt that campaigns should continue to spread information about HIV/AIDS and sexual health.

Too much information isn’t enough when it comes to AIDS. It might be a topic that’s been covered a lot of times, but I don’t think there’s ever enough information about it, because people are still dying, you know?
Traditional beliefs and practices. Traditional beliefs and practices in Botswana have often been blamed for accelerating the spread of HIV/AIDS (Chipfakacha, 1997; Simmons, 2009). However, responses from young adult participants in the current study suggest that these methods and beliefs are fading from the city-dwelling, young and educated generations. Out of all three focus groups, none of the participants claimed to believe that HIV/AIDS could come from sorcery or witchcraft. As one participant noted, “they used to think that way before the whole explanation about HIV came about.” The results from the questionnaire also suggest that the participants were well-informed about the various myths and misconceptions about HIV/AIDS. All of the participants either agreed or strongly agreed to the statement, “I will follow the advice of a doctor over the advice of a village elder or chief.” When presented with a hypothetical case scenario in which the participant was asked to allow a traditional doctor “to cut your skin and apply and powder to heal you,” all of the participants responded that they would either refuse the treatment or have the equipment sterilized first.

Many of the participants expressed a frank disregard for traditional practices of the past but claimed that some of their parents and other members of the older generations still believe in those methods and will consult traditional doctors and healers. As one participant wrote, “My parents may believe in things of the past which are based more on culture, while I am born in a new modern generation.” The young adults recognized the fact that access to information about HIV/AIDS through modern media and technology has greatly reduced the support of the older beliefs, especially among the younger generations. One participant noted
this disparity and said, “At that time, they didn’t know much about HIV, like we do.”

Multiple responses supported the idea that there are generational differences in beliefs.

*The issue of HIV being from witchcraft was a belief when the topic was still relatively new in Botswana. Because as Africans, there’s this concept that anything happens that you cannot explain, it’s on the supernatural side. So when HIV could not be explained when it started, they said ‘Hey let’s put everything on witchcraft and sorcery.’*

There’s a lot of education about sex, about HIV and how you can get it and people have come to accept witchcraft doesn’t really deal with sex anymore.

*I don’t think there’s anyone who would like, if they have AIDS they would say ‘Oh my God, I’ve been bewitched.’ Cause they knew what they’ve been up to.*

One historic practice that has remained relevant to some of the younger generations is the tradition of sending young boys to initiation schools. “It doesn’t happen a lot,” explained one participant. “It only happens among a few tribes. The yearly initiation of the boys, where they cut, they circumcise boys.” Participants noted that medical doctors are becoming more involved in the circumcision rituals, but strict secrecy prevents boys from telling anyone what occurs at initiations.
Beliefs

**Perspectives about HIV/AIDS.** The focus group discussion and questionnaire included a series of questions about participants’ personal perspectives, fears, knowledge, and motivations in relation to HIV/AIDS and prevention behaviors. According to the results from the questionnaire, out of the 21 participants, 11 did not know their HIV status at the time of the focus groups. The proportions of participants that did not know their status were equally represented between the sexes. All participants reported that they either agree or strongly agree that there are resources available for HIV information. However, only one participant correctly identified the most recent HIV prevalence rate for Botswana. In fact, 14 participants actually overestimated the prevalence rate, believing it to be 32.8% rather than 23%. While this reflects a relatively small inaccuracy, the inflated prevalence estimates suggest that participants feel a heightened sense of risk and vulnerability to HIV/AIDS. This sentiment was evident throughout the discussion.

*I see it as an odor in the air. In the sense that it can just easily get to you.*

*You’re not protected of anything, whether you are rich or poor or black or white or whatever, it can get to you.*

Many of the participants expressed negative emotions toward HIV/AIDS, including fear and anger.

*HIV means suffering, not only just for you, but the people around you. I don’t want to end up being taken care of like an infant.*
In the questionnaire, more than half of the participants answered that they are worried, to some degree, that they may contract HIV someday. However, the majority of respondents also answered that they believed it is easy to prevent getting HIV and that they felt in control of their HIV status. When asked about the reasons why people become infected with HIV, most participants answered that unprotected sexual intercourse is the leading cause of transmission.

**Personal responsibility.** Many participants noted the importance of personal responsibility for health decisions and blamed the HIV prevalence on ignorance.

*A lot of information has been given to us. It's up to us. There's just too much has been said, too much has been done. It's up to us to make the right decisions. It has nothing to do with what the government is doing or what's been happening on TV or billboards. It's up to us now to make the right decisions because we know. We know, we're just ignorant.*

The concept of personal choice was echoed several times in the discussion.

*It just depends on the individual. The information is there. What you chose to do...if you choose to listen to your friends and lead a promiscuous life or you chose to stay healthy.*
These days, we have a lot of information. We are exposed to a lot of information. You turn on the radio, any number of stations, they will not fail to mention something about HIV and AIDS. Turn on the TV. Go on to Facebook. You will not fail to find something about HIV and AIDS. What we do is we choose not to listen. We choose not to see. We choose to close our minds off to everything that is around us. We choose to ignore everything that is in front of us. And we choose to just be young and have…we choose fun over life.

Participants stated that they felt that there is a sufficient amount of information available about HIV/AIDS and that it is a personal decision to pay attention to the information and act upon it to protect oneself.

Everywhere these days, whether it be TV, radio, pamphlets, as she said, medical facilities, they speak about HIV/AIDS. They speak about this issue, they tell us everything we need to know.

I think everything is there, it’s just that we ignore it.

Participants recognized the fact that HIV/AIDS could be spread through rape or accidents involving blood exposure. Despite this awareness, some expressed a feeling of callousness and resentment toward those infected.
I feel anger because it can be...AIDS is something that can be prevented. We have all the information that we need. Unlike things like cancer or other diseases, HIV can be prevented. People have the responsibility to do it. If I see someone dying from AIDS, I feel like it is their fault or something like that. Like they should have done something.

If I hear that somebody has died of AIDS, basically I don’t feel anything. Because as she said, it’s something that you can prevent. We have all of the information. And then when ignorance takes prevalence over knowledge, I can’t be expected to feel...to waste my emotions on somebody else.

Antiretroviral therapy. Participants were knowledgeable about the availability of ARV therapy, and cited their medical use often. However, the young adults revealed that the universal availability of free ARV medicine in Botswana may actually lead to indifference and/or risky behaviors. One participant said that some people become careless with contraceptives because “they know they have an option, you know? And that option is ARVs.” This issue was repeated in different focus groups.

Thing is, they’re providing free pills...free medication...so some people just say ‘Ah, we’ll just go get the ARVS, they’re just there.’ Because in some countries they have to buy them. They’ll be like ‘Yeah, I’m not the first one. I’m still alive. They’re still developing’.
One of the problems that we can have in Botswana is that these ARVs are offered for free, you know. People don’t care anymore, even if you get HIV/AIDS, you know there’s ARVs provided for free.

Access to information. While many of the participants felt that there is an overabundance of information and advertising about HIV/AIDS, they repeatedly recognized that there is an unequal dissemination of information.

I wouldn’t say that enough information is being passed around, I mean, some people are not getting it at all. So I wouldn’t say that the government should stop giving information or should stop anything that involves HIV. It should be encouraged.

Participants stated that rural areas are especially disadvantaged from lack of modern technologies. As one participant stated, “They should focus more on the rural areas. There, they don’t have even radios around there. So they can’t get any information about HIV.”

Others felt a sense of empathy for those that are infected as a result of misinformation or lack of resources. “When you hear that someone died of HIV, you feel sorry for those people. They may not have the information about HIV. They get exposed and get infected.”
Stigma

Participants repeatedly pointed to stigma as one the biggest obstacles for personal decisions and actions regarding sexual behavior and HIV/AIDS prevention. Fear of being accused of having AIDS prevents many from taking precautionary steps or even educating themselves about HIV/AIDS.

You don’t want to find out about AIDS because if you’re found on the laptop researching about AIDS, someone will assume you have AIDS. You understand? You don’t want to go through the trouble of buying condoms because they’ll assume, people will look at you and say, ‘getting AIDS and having sex already.’

Stigma and judgment is unavoidable, even at testing centers or clinics, where participants said they have to be cautious to not be seen.

I go to a private hospital, where like it’s not in public. Because there’s this whole shame thing that’s addressing us as teenagers. If you are seen entering the public ones, like the clinics... they are looking at you, thinking, ‘oh so he did something. So he probably has HIV or something like that.’

Evidence of stigma was prominent in many personal accounts that were shared during the focus groups. One participant shared the fact that she was turned away from a testing
center on the basis of her age. Another member noted that some mothers will continue to
breastfeed in fear of being “found out” as HIV-positive.

*People know that if you’re not breastfeeding, that means you have AIDS, so
they do it anyway. They would rather kill their child...and save themselves the
embarrassment.*

Deterred by the heavy stigma, some remain uneducated about HIV. As one participant said,
“It’s ignorance, being afraid of being judged as well. It’s one thing that will kill a lot of
people and get them into trouble.”

Conversations. While HIV/AIDS is regularly featured on billboards, radio
programs, television shows, and other popular media platforms, the focus group discussion
revealed that the topic rarely comes up in conversations at home.

*Sometimes parents find it difficult to talk to their kids about sex because it
brings a certain atmosphere of discomfort. In Botswana, it’s not really
normal for a parent to talk about such sensitive cases with kids.*

The participants claimed that asking questions about sex or HIV/AIDS would signal
to the parent that they are sexually active, which would fuel suspicion and only get them in
trouble. As one participant explained, “*It’s not easy to turn to parents to talk about such*
sensitive issues because a lot of parents, they become suspicious.” Participants noted that religious standards add another barrier to open conversation about sex in the home.

To talk to your mother or your father about AIDS when you’re just from church and hearing that sex is for married people, you know, it’s another one of those things, to bring it up and have them think that you’ve disappointed them.

Participants said that in general, parents don’t bring up sex and HIV/AIDS because they “assume we get told elsewhere” and “don’t want to talk about it.” However, this pattern may change with time. Participants insisted that in the future, when they have children of their own, they would make a deliberate effort to talk to their children about HIV/AIDS. Participants believe that the way to initiate open conversation in Botswana is through early communication with parents and guardians. One contributor said, “When I grow up and have my own kids, I would want them to talk to me about it. I want to very open.” Other participants predicted that conversations involving sensitive topics will be easier in the future.

I think this generation is much more open than the previous generations, so it’s going to be easier for us when we’re older to talk to our children about sex, HIV and relationships and stuff.
Among friends, participants said that they discuss sex, and even sometimes condoms, but not in relation to HIV or AIDS. One participant admitted that “for people our age, pregnancy is the main concern when it comes to sex.” Participants recognized the fact that the stigma surrounding HIV/AIDS and sex prevented open conversation and cooperation to eradicate HIV/AIDS. As one participant said, “If people started being open about sex, you know, it shouldn’t be That Thing.” The gravity and denial of sex prevents honest conversation that is necessary to break the stigma of HIV/AIDS.

*I think you also have to change the perceptions about sex. We know that in Botswana, as much as we talk about sex, it’s also more of a private matter, you know? People don’t talk about it a lot. People are afraid of it, even though they do it.*

**Condoms.** The topic of condoms was a recurring central theme throughout the focus group discussions. Participants regularly indicated that the use of condoms was essential to preventing the spread of HIV/AIDS, but explained that access to condoms is a problem choked by a heavy stigma in Botswana. As one participant explained, “It’s not difficult to use them, but it’s difficult to obtain them.” Purchasing condoms at a public grocery store is seen as an obstacle for young adults, who are often too embarrassed to buy them, fearing judgment because of their age.

*I think it’s the reaction that comes from the adults. Like if you’re my age and*
you’re grocery shopping and you buy a packet of condoms, when you get
to the people, eventually that person that’s working at the till, they’re going to
wonder... ‘what are you going to do with these at your age?’

Participants admitted that they are afraid of being judged if they are seen buying condoms
from a store or collecting free condoms at a clinic or from a public dispenser.

It’s a big thing. We’re always wondering who’s looking. They’re probably
thinking I’m going to do it today or something like that.

The discussion revealed that judgments about condom purchasing is different between the
sexes.

I think it’s also gender based. If a guy who’s twenty comes in the shop and
buys condoms, it’s ok. If a girl comes and she’s like twenty or eighteen, it’s
going to be like ‘What, that girl!’ You know? I think it’s also gender-based,
like that. If it’s a guy it’s ok. If it’s a girl, it means she’s...THAT girl, you
know?

While reactions from older adults are the cause of anxiety in public shopping centers,
the young adults noted that peers can be just as judgmental about possession of condoms.
The participants agreed that partners have equal responsibility when it comes to using
contraceptives, but they said that young women may be judged if she has condoms in her possession. As one participant explained, the belief is that “only sluts carry condoms.” Others said that some people assume that adamant condom users are HIV-positive. It is believed that “people who use condoms that are usually infected.”

Participants also reported that contraceptive use is occasionally abandoned in long-term relationships. A couple of members noted that some people consider sex and contraception to be a test of a relationship. “It’s a trust issue. If you don’t trust your partner then you’re going to use protection but if you do, you’re not.” Another said that, “I think maybe for a few people who may be thinking that they’re in stable relationships, they chose to have sex without using a condom.”

**Discussion**

Findings from the focus groups provided great insight into the experience and personal beliefs of young adults living in Gaborone, Botswana. Responses from the discussion can help to identify the weaknesses of current campaigns, the social structures and beliefs that spread HIV/AIDS, and the motivations and fears that young adults experience in modern-day Botswana. This in-depth understanding can serve as a guide for future prevention campaigns and appeals. While ARV therapy has alleviated some of the suffering due to HIV/AIDS, the prevention of future infection must be the focus and priority for Botswana’s public health efforts. Examining young adults’ beliefs and attitudes using the Health Belief Model helps to critically assess potential motivations and obstacles behind prevention behaviors. A focused effort to understand the societal and cultural factors in
Botswana is necessary to build effective campaigns and programs that will motivate behavior change within the population and end the spread of HIV/AIDS.

**Experience with HIV/AIDS**

The focus group discussion revealed that the young adults are well aware of the campaigns around them, but are generally unsatisfied with the quality and efficacy of the prevention messages. Additionally, at the time of the focus group, half of the participants did not know their HIV status, which speaks to the general failure of current efforts. Participants were unresponsive to many of the repetitive campaigns that promote condom use or abstinence, but recognized the need for more detail in prevention communications. Endorsing general condom use is not enough anymore. Rather, billboards and other advertisements should be specific about the differences in protection for various condom materials and should feature more substantial information about the female condom. The importance of consistent condom use should also be highlighted. Participants disclosed that people in long-term relationships or those that trust their partner may abandon the use of contraceptives. Since many campaigns concentrate on the dangers of multiple concurrent partners, steady or long-term relationships may not be strongly associated with risk. This phenomenon should be recognized and managed in future campaigns.

Drama that promotes health behaviors and prevention has been used for many public health campaigns about HIV/AIDS in Africa (Barz & Cole, 2011). Specifically, the South African Broadcasting Corporation television show *InterSEXtions* was recognized as an interesting and persuasive television program in the focus groups, while Botswana’s
productions were not regarded favorably. Local television networks in Botswana, especially BTV, should work to develop more dynamic drama programs that will interest the young adult crowd and portray a more realistic view of HIV/AIDS that is not exclusively attached to death and illness. Responses suggest that participants desire a television program that features healthy PLWHA who continue to be productive members of society. Currently, the media representation of HIV/AIDS is closely associated with death and/or extreme sickness, which is not the only reality for those who are living positively and adhere to ARV therapy.

One of the most significant findings from the discussion was that participants are becoming desensitized and indifferent to HIV/AIDS risk as a result of excessive exposure to prevention messaging from a variety of media over an extended amount of time. This response is best explained using alert fatigue, which is a relatively new concept to communication research. Doctors who repetitively override medication alert warnings for patients are said to experience alert fatigue (Baker, 2009). “One of the unintended consequences of a growing number of alerts (in the interest of patient safety) is the potential for user desensitization” (Cash, 2009, p. 2098). Another study done with health care providers in Washington found that receiving repetitive information from multiple communication channels resulted in lower recall of health alert messages. In fact, increasing the amount of alert messages received per week by as little as one resulted in a 41.2% decrease in content recall of the message (Baseman et al., 2013). This research points to the potentially harmful effects of repetitive stimulus resulting in desensitization or fatigue.

Alert fatigue is an extraordinarily relevant and valuable concept to assess the prevention situation in Botswana. Young adults who have grown up in a society that is
highly affected by HIV/AIDS have become desensitized to the effects and risks associated with the virus because of the incessant presence of repetitive prevention campaigns. To combat the overexposure to alert messages in Gaborone, health organizations should reexamine current campaigns and attempt to improve on quality while reducing the amount of repetitive prevention messages. To alleviate the abundance of uneffective campaigns, all organizations that fund HIV prevention programs in Gaborone, Botswana should conduct a thorough analysis of current campaigns and eliminate those that are not succeeding. Rather than spending money on a billboard that does not affect or influence young adults, interactive programs should be introduced at younger ages. Participants expressed the need for training in practical tips that young people can utilize in risky situations. Rather than urging young adults to abstain from sex and avoid social situations with alcohol, programs should provide practical steps for negotiating risky situations and socializing safely. Many students and young adults are not willing to avoid sex or partying altogether. Campaigns should provide safe alternatives or methods for those that choose to engage in social parties or those that engage in sexual intercourse.

Equally important, participants indicated that many in the distant rural areas do not have access to many of the technologies that disseminate information about HIV/AIDS. To resolve this, future prevention campaign should try to build more connections with rural areas rather than exclusively allocating health messages in the developed areas.

Traditional healers and doctors of Botswana have been shown to accelerate the spread of HIV/AIDS in the past. Some of these traditional practices and rituals may still be relevant to the older generations in Botswana and to some people in rural areas. However, the results
from the questionnaire and responses during the focus groups demonstrate that the young adult population in Gaborone does not subscribe to those traditional beliefs and are not at a high risk of becoming infected through ethno-medicine.

Participants explained that all schools in Botswana educate about HIV/AIDS, but the applied methods and curriculum vary. While some students receive a thorough demonstration and opportunities to practice certain prevention methods, others are only given a textbook explanation of HIV/AIDS. Those that did not receive interactive lessons or merely received a cursory academic lesson are at a disadvantage. To ensure that all students equally receive the information and skills that are necessary to prevent HIV infection, training programs should be implemented nationwide to instruct and prepare teachers for a universally effective education about HIV/AIDS. Educational programs should be conducted through primary schools to reach children before they develop a mental block to HIV prevention campaigns. By introducing the facts about HIV/AIDS at a young age, children can begin to develop safe behaviors and can feel comfortable talking about it.

As the participants noted, the consumption of alcohol is a common source of entertainment in Botswana. Research has shown that alcohol use is linked to HIV/AIDS risk behaviors in Botswana (Weiser et al., 2006). However, the current campaigns which promote total abstinence from alcohol consumption are considered to be ineffective among the young adults of Botswana. Instead, prevention advertising featuring alcohol risk should offer alternatives to drinking or give practical tips on how to socialize safely or reduce alcohol use.
Participants also indicated that without personal connection to the disease, it is difficult, if not impossible, to fully comprehend HIV/AIDS and understand the risk involved. This finding points again to the importance of open conversation about HIV/AIDS that involves the inclusion and personal stories of people living with HIV/AIDS (PLWHA). In Botswana, those that become infected and those that die from AIDS or from a resulting opportunistic infection are shrouded in secrecy. If people living positively came out of the shadows, the realities of HIV/AIDS would be more tangible for the public to grasp and perhaps, the consequences of risky behaviors will become more real for people to comprehend.

**Beliefs about HIV/AIDS**

It is imperative to understand the cultural beliefs that young adults hold about HIV/AIDS in order to build campaigns that will successfully educate and motivate viewers. “Culture is the foundation on which health behavior in general and HIV/AIDS in particular is expressed and through which health must be defined and understood” (Uwah & Ebewo, 2011, p. 200). The focus group discussions revealed meaningful perspectives about the values and fears of modern young adults in Botswana. First, it is important to note that most participants felt that there are plenty of resources available in Botswana for those who wish to learn about HIV/AIDS. Focus group members stated that the high rates of infection are not due to any lack of information, but rather, they are a result of ignorance or a failure of the public to heed to the prevention messages that surround them. The elimination of HIV/AIDS, they said, is not dependent on governmental action or flashy television shows,
but on the role of personal responsibility and individual decisions. Beliefs about personal responsibility may explain the comments from participants that seem callous toward infected persons and place blame on individuals that have AIDS. The prominent narrative in prevention campaigns maintains that the control of serostatus lies in use of contraceptives and personal sexual decisions. The stories of those that are infected unintentionally or through traumatic events such as rape are left out of the discourse. To reduce accusatory attitudes and judgments, future messages should equally represent personal choices and the community’s responsibility to tackle HIV/AIDS collectively.

The HBM suggests that the perceived threat of an illness includes the susceptibility that an individual feels toward a health threat and the severity of the illness (Clemow, 2004). In the questionnaire, the majority of the participants overestimated the HIV prevalence rates in Botswana. This feedback suggests that the overabundance of HIV/AIDS messaging has resulted in a skewed sense of susceptibility among some young people in Botswana. The participants hear so much about HIV/AIDS that they assume the risks are greater than reality. They feel a strong sense of danger, proportionate to the quantity of prevention messages, but do not have an accurate idea of the actual threat. The perceived susceptibility to HIV/AIDS impacts the decision-making process. Nearly one quarter of the population in Botswana has HIV, which is a relatively high level of threat. However, it is important that viewers have an accurate sense of susceptibility in order to take appropriate steps to protect themselves. If the perceived level of threat is too high, people may feel powerless or overwhelmed.

Self-efficacy, as another component of the perceived threat in the HBM, “refers to the level of confidence a person feels regarding his or her ability to perform a behavior”
According to responses in the questionnaire, the majority of participants felt in control of their HIV status. However, this finding seems to contradict research about the gender disparities associated with susceptibility and control in relationships. Previous research shows that females are at an elevated risk of contracting HIV/AIDS because cultural and social views of gender and power prevent women from having the ability to insist on condom use (Greig & Koopman, 2003; Langen, 2005; MacDonald 1996; Ntseane, 2004). Historically, in Botswana, women are more susceptible to HIV/AIDS and have less control over their health. The female participants that declared that they felt in control over their HIV status did not address any gender issues that may prevent them from contracting HIV/AIDS. These women may be relatively inexperienced as a result of their young age and may not have personally experienced oppressive relationships that are so well-documented in research. They may feel capable of control over their health, but seem to be unaware of the various situations that may hinder their ability to insist on protection. The fact that the female participants did not acknowledge the gender power inequality in susceptibility and control is also evidence that these issues are also absent from prevention campaigns. The HIV/AIDS epidemic in Botswana will not be stopped until women are empowered and have the ability to insist on safe sex. The gender power gap must be addressed in future HIV/AIDS prevention campaigns, with specific attention given to devices which give women more control, like the female condom.

Participants also indicated that they believe the availability of free ARV therapy has led some to become complacent with risky behaviors. This theory has not been investigated through research, but it is significant that it was repeated among different focus groups and
should be considered in future research.

Overall, the participants had negative associations with HIV/AIDS, correlating the virus and disease with death, extreme sickness, and becoming a burden to others. This mental connection is probably the result of the reinforcement of those ideas through mainstream media and dramatic programs. Nearly one quarter of the population of Botswana is HIV-positive and many of those people are healthy productive members of society. But their stories are not featured on television or the radio, so the assumption is that people with HIV/AIDS are either extremely sick or dying.

Stigma

As campaign research shows, to support and boost prevention efforts, societal aspects of the target culture must be closely examined and utilized. Issues involving sensitive subjects, such as sexual behaviors and beliefs, are cushioned within the values, motivations, and beliefs of a society or community and cannot be considered universally relevant or supported. In the case of Botswana, topics about HIV/AIDS and sex are pervaded with stigmatic beliefs and attitudes which permeate all social and cultural conditions. Participants disclosed that stigma affects many aspects of prevention, including research, conversation, condom use, and testing.

The current study examined stigma beliefs using the HBM, which claims that decisions to act upon prevention behaviors are evaluated through the assessment of perceived barriers, benefits, and threats, among other variables (Clemow, 2004). One dimension of the HBM is the perceived barriers to preventative behaviors, which are “the potential negative
aspects of a particular health action (which) may act as impediments to undertaking the recommended behavior” (Janz & Becker, 1984, p. 2). Young adults face several barriers as a result of the stigmatized beliefs of the community. Participants revealed that young adults who wish to educate themselves about HIV/AIDS and protect themselves from infection face complex social barriers and discrimination. For young people in Botswana, being seen at a testing center, purchasing condoms, or even simply researching HIV/AIDS at a library could result in humiliation and suspicion. These social barriers are a significant impediment to the prevention of HIV infection.

Although contraception and sexual behavior are regularly mentioned in public billboards, radio advertisements, and television programs, the participants said that these topics are not discussed openly in interpersonal and family relationships. Sex may be discussed among friends, but very rarely in terms of prevention or risky behaviors. The majority of participants said that they could not have a conversation with their parents about HIV/AIDS. It is promising that the participants intend to discuss HIV/AIDS and sex with their future children. “Early, clear conversation between parents and young people about sex is an important step in helping adolescents adopt and maintain protective sexual behaviors” (Osei-Hwedie & Namutosi, 2003, p. 308). However, these changes will not be instantaneous in the current social environment. To facilitate open conversation in the home, the community must be a place of honest discourse about HIV/AIDS which includes PLWHA.

Although Botswana is heavily afflicted with HIV/AIDS, there is no open conversation about the behaviors that lead to infection. Prevention campaigns in Botswana will not be successful until the community is able to have candid conversation about
HIV/AIDS. To facilitate that conversation and to break the stigma surrounding HIV/AIDS in Botswana, it is necessary to feature the stories of PLWHA. The necessity of open conversation and honest communication about sex and HIV/AIDS was a prevalent theme during the focus group: “If you want people to start talking about something, it’s really good to talk about your own experience.” Respondents from a previous study at the University of Botswana reflected the same desire to collaborate with HIV-positive people. “Students felt strongly that such interaction would help them overcome their own denial, fears, and prejudices and lessen the stigma attached to the disease” (Brown et al., 2008, p. 324).

The incorporation of people living with HIV/AIDS is being used successfully for HIV/AIDS prevention in other parts of Africa. In 1999, South African national television started a program called Siyayinqoba/Beat it!\(^1\) that sought to demystify the issues which HIV-positive people face. “Through constant portrayals of a diverse range of HIV-positive people who talked honestly about matters ranging from the banal to the most private, the show sought to desensationalize the disease” (Hodes, 2011, p. 160). Portraying the truth of what is means to live positively brings HIV/AIDS out of the shadows and encourages public discourse rather than secrecy and shame.

**Solutions: TASO**

Since the 1990s, Uganda has been a great example for success in reducing the spread of

\(^1\) Television program co-produced by SABC Education and SABC 1 that “promotes positive living, treatment access and prevention of HIV infection both for the uninfected and people living with HIV” (Siyayingqoba).
HIV/AIDS (Nabulime & McEwan, 2011; Yartey, 2011). Uganda is “considered by UNAIDS and others to be one of the world’s earliest and most compelling national success stories in combating the spread of HIV” (Green et al., 2006, p. 336). Through effective marketing and social promotion, HIV prevention campaigns in Uganda were able to facilitate an open discussion of the epidemic and establish new norms in the community (Hanson, 2005). As a result, Uganda has been able to successfully reduce both HIV prevalence and incidence (Barnett & Whiteside, 1999).

The prevention campaigns in Uganda during the late 1980s consisted of mass advertising and education. Through the use of billboards, radio, and informational flyers, the campaign focused on community-based communication to educate and persuade the population (Green et al., 2006). “Strong nongovernmental organization (NGO) and community-based support led to flexible, creative and culturally appropriate interventions that helped facilitate individual behavior change” (Green et al., 2006, p. 338). The campaigns in Uganda were a great success. In the early 1990s, the HIV prevalence rate of adults in Uganda peaked at around 15%, but in 2004, the national prevalence rate had fallen to around 4% (Green et al, 2006). A survey done by the WHO in 1989 and 1995 showed that sexual behavior had changed overall as well. “In the GPA surveys, the proportion of single males ages 15-24 reporting premarital sex decreased from 60% in 1989 to 23% in 1995 (Green et al., 2006). Reporting of “casual sex” dropped among men from 35% to 15% and among women 16% to 6% (Green et al., 2006, p. 337).

Uganda and Botswana have vastly different geographical locations and uniquely different cultures. However, it is instructive to compare the campaign strategies of the two countries
to improve the efficacy of HIV prevention. Uganda has been able to improve, if not overcome, many of the same cultural and social barriers to HIV/AIDS prevention that Botswana faces today, including community silence and stigma. One of the major differences between prevention efforts in Uganda and Botswana is the incorporation of PLWHA in campaigns, community acceptance, and the ability to have open conversations regarding HIV/AIDS and sex. One organization that seeks to promote an open conversation with PLWHA in Uganda is The AIDS Support Organization (TASO). TASO is an NGO that provides counselling, medical care, and social support services for HIV infected and affected people. An evaluation of the organization found that “TASO counselling services helped clients and their families to cope with HIV and AIDS, with 90.4% of clients revealing their serostatus, and 57.2% reporting consistent use of condoms in the past 3 months” (Kaleeba et al., 1997).

To break down stigma and open the community conversation about HIV/AIDS, a group of HIV-positive TASO clients formed a group that travels around the country, singing and performing music with messages that promote education, testing, hope, and the acceptance of PLWHA. “The drama performances depict different scenarios of living with HIV/AIDS, with the aim of creating awareness among the communities, increasing acceptance of PWAs and boosting their coping capacity” (Kaleeba et al., 1997). Through music, drama, and testimonies, the group is able to educate the community and dismantle common misconceptions and assumptions about AIDS. One scholar, after spending an afternoon with the TASO Mbarara drama group found that the music “provided a medium for listeners and performers to connect with a national, mass-mediated style--one that is helping contextualize
the epidemic as something that is itself widespread and international” (Cohen, 2011, p. 130). By prominently featuring the stories of healthy, happy people who are living positively, this group has been able to bring HIV/AIDS out of the shadows, which leads to a greater acceptance of PLWHA. As a result of TASO services, “there was a high level of acceptance of people living with HIV/AIDS (PWAs) by families (79%) and the community (76%)” (Kaleeba et al., 1997)

Music has been used in many African cultures as a tool for HIV/AIDS prevention. “The maintenance of community health demands that the musical arts remain relevant in the face of developmental challenges such as HIV/AIDS” (Cole, 2011, p. 146). “Music in this context is not a ‘therapy,’ nor is it a way to alleviate pain. Rather, it serves an important role in negotiating community values that will likely lead people to make crucial choices about their own health” (Cohen, 2011, p. 130). Music allows communities to change the conversation about HIV/AIDS and to overcome social boundaries and fears. “Dancing, singing, drumming, traditional rituals, and ceremonies...because the dramatization enables patients to express their emotions, overcome anxiety, and accept and integrate what may seem like a threatening part of him or herself” (Uwah & Ebewo, 2011, p. 208). Using music strategically to spread information about HIV/AIDS was also proposed in the focus group discussion. A participant suggested, “I think many people like music, so I would spread the message through music because people are always listening to music.” Botswana would benefit from utilizing Ugandan strategies. Disseminating prevention information featuring PLWHA through locally-produced music would be an effective way to rise above the prevention noise and open up the conversation about HIV/AIDS in Botswana.
Limitations

As a result of limited time and funding, the current study did not conduct focus groups in the rural areas outside of Gaborone. About half of the population of Botswana is spread out among rural lands, which tend to have limited access to technology. Future studies should include discussions and surveys among rural young adult populations, who may have very different values, information, and experiences with HIV/AIDS prevention than the young adults living in the capital city. Many prevention campaigns utilize technology and media to spread information and promote safe sexual behaviors. Lack of access to those avenues may deter the influence of prevention campaign among rural populations.

Recruitment directed to young adults that have previously engaged in HIV/AIDS research may imply that those individuals have an elevated personal interest or investment in the topic. Those participants may be more involved in HIV/AIDS subjects and may tend to seek out more information than their peers. The process of recruiting for the study was also limited because of the disproportionate representation of females (66.7%). Future studies should recruit by advertising to the general public, to avoid an overconcentration of well-informed people, and should make an effort to include an equal number of male and female participants.

The study was also limited in terms of language ability. Focus group discussions were carried out in English exclusively. Every one of the participants was fluent in English, which is an official language in Botswana, but the local language, Setswana, was not utilized. However, to ensure maximum comfort and encourage the most honest, natural conversation,
it may have been more effective to utilize Setswana in the focus groups. Future studies should be conducted by a local person from Botswana, who can direct the focus groups and encourage conversation in Setswana. The cultural gap between the researcher and the participants may have also hindered honesty and openness in some cases. If the participants felt socially distant from the researcher, they may not have expressed all of their personal thoughts candidly.

**Conclusion**

Findings from the focus groups suggested that stigma is the greatest challenge in the community for talking about HIV/AIDS, taking steps to prevent HIV/AIDS, and to spread information about HIV/AIDS. The young adults are afraid to buy condoms or discuss HIV/AIDS because the epidemic is bound with a stigma of shame and death. Through heavy campaigning and advertising, the participants perpetually feel the presence of HIV/AIDS, but do not have a chance to boldly address the issue. Fear prevents many from searching for information or getting tested.

Responses from participants seem to suggest that many of the old traditional practices that encouraged the spread HIV are gradually disappearing as the population ages. The participants are well informed on the various ways that HIV can be spread and how to prevent infection. Many claim that they do not subscribe to the rumors, misconceptions, and beliefs about AIDS that their parents or grandparents may accept. Instead, a new problem has emerged within the young adult population—excessive messaging, resulting in risk fatigue. The participants admitted, during the focus group discussion, that they have all
heard so much about HIV and AIDS for so long that they no longer pay attention to the messages. The over-abundance of prevention campaigns has made them numb to possible influence. Stories and facts about HIV/AIDS are thrust upon them from all sides, including social networks, radio programs, television, and billboards. The frequency and intensity of all the various campaigns has pushed the young adult generation to develop a somewhat mental block to everything that they see or hear about HIV/AIDS.

The problems and challenges of preventing the spread of HIV/AIDS in Botswana have changed over time, adapting and responding to the societal development and modernization of the people of Botswana. To successfully encourage behavior change and promote an environment of open communication and information that will facilitate a lower rate of HIV infection, HIV prevention campaigns in Botswana should re-evaluate the frequency of repetitive messages and should include the stories of PLWHA in the public discourse. Perhaps the solution to the stigma that stifles HIV prevention in Botswana is not to be found in the calculated language of research plastered on strategic billboards or printed in elaborate posters, but in the power of open conversation and disclosure involving PLWHA.
References


Datta, K. (2007). "In the eyes of a child, a father is everything": Changing constructions of


Hodes, R. (2011). "we are the loudmouthed hiv-positive people": "siyayinqoba/beat it!" on south african television. In The culture of aids in africa (pp. 158-179). New York: Oxford University Press.


Management, 17(1), 5-23.


botswana aids impact survey iv (bais iv), 2013. website:


http://data.worldbank.org/country/botswana


Appendix A

Questionnaire

Please answer the following questions below. Do not put your name anywhere on this form.

1. How old are you? ____ years old
2. Where were you born? ___________________
3. What is your biological sex?
   A) Male
   B) Female
4. In a normal week, how many times do you see or hear an advertisement about HIV prevention?
5. Do you know your HIV status? DO NOT REVEAL YOUR HIV status. Just indicate whether you know what your status is.
   O Yes
   O No
6. Please rate the extent to which you agree or disagree with each statement. (put an X in the box)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I worry that I may contract HIV someday.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is easy to prevent getting HIV/AIDS.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional medicine works better than contemporary medicine.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel in control of my HIV status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being HIV positive is shameful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel like there are resources available to me if I need HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If I became infected with HIV, I would be able to receive treatment fairly easy.

It is easy to find contraception (condoms or birth control) if I need or want it.

I will follow the advice of a doctor over the advice of a village elder or chief.

Having children is important to me.

The HIV prevention campaigns that I have seen are effective.

7. (Circle true or false) HIV can be spread through breast-feeding.
   True    False

8. HIV can be spread through cutting a person’s skin with a blade that has not been sterilized.
   True    False

9. HIV can be spread through witchcraft or sorcery.
   True    False

10. What do you believe is the #1 most common reason that someone is infected with HIV/AIDS?
11. If you felt ill, and suspected that you may have HIV, what would you do?

12. Have you been to see a traditional doctor within the last year? If so, what was the reason for your visit? What happened at the visit?

13. Case scenario: You are feeling sick and a family member demands that you go to see a traditional doctor. When you go to consult the doctor, he says that he is going to cut your skin and apply a powder to heal you. What would you do?

14. Do your beliefs differ from the beliefs of your parents? How?

15. What are the 5 things that you value the most?
   1)_____________________________________
   2)_____________________________________
   3)_____________________________________
   4)_____________________________________
   5)__________________________

16. What is the current HIV prevalence rate in Botswana?
   A. 15.2%  C. 32.8%
   B. 24.8%  D. 11.6%