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CONDOM USE AND HIV/AIDS: PRECAUTIONARY BEHAVIOUR AMONG BOTSWANA YOUTH

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ABSTRACT

The article is based on a research study of a random sample of 250 young people aged between 12 and 18 years attending private secondary schools in Gaborone. The main focus was to assess young peoples' attitudes towards and knowledge of HIV/AIDS precautionary behaviour, and the link between certain behaviours such as inconsistent use of condoms and HIV infection. It is evident that young people are very knowledgeable about precautions against HIV/AIDS, and the relationships between certain behaviours and HIV infection. However, this awareness does not necessarily translate into change in sexual behaviour.

INTRODUCTION

The last two decades have witnessed a gradual extension of the HIV/AIDS pandemic to virtually all communities in all parts of the world. At the end of 2001 an estimated 40 million people around the world were living with HIV/AIDS (UNICEF *et al.* 2002). In many developing countries the majority of new infections occur among young people, especially females. About one third of those currently living with HIV/AIDS are aged between 15 and 24 (WHO 2001). Sub-Saharan Africa is the worst affected region, with more than 28 million, including over 1 million children, living with HIV/AIDS at the end of 2001. Of all the deaths that have occurred since the epidemic started, 83% have been in sub-Saharan Africa which also had 75% of all new infections (NACA, 2002).

Botswana holds the unenviable position of being among the countries that have been hardest hit by the worldwide HIV/AIDS epidemic. At the end of 2002 there were an estimated 330,000 people in Botswana living with HIV/AIDS. This, in a country with a total population of 1.6 million, gives Botswana a prevalence rate of about 39%, the highest in the world (UNAIDS 2002). In addition, the Botswana Technical Working Group on the UN Special Session on HIV/AIDS (2001) estimated that 17% of the country's population is living with HIV; 38% of the population aged 15-49 years are infected, the majority of whom are women; the age group 25-29 years is the worst affected with a prevalence rate of 52.3%, followed by the 20-24-year-olds with a prevalence of 42.3%, and that by 2010 about 20% of all children would have lost their mothers due to AIDS.

On the basis of the above figures, it is necessary to assess the level of sexual awareness and the factors that undermine precautionary behaviour among young people in Botswana. The paper, therefore, discusses young people's attitudes towards, and knowledge of, HIV/AIDS precautionary behaviour, and the link between certain behaviours such as inconsistent use of condoms and HIV infection. The target population of the study was students. The study used stratified probability sampling in order to obtain a representative sample. Baker (1999) indicates that it is only through probability that one can obtain representative samples. The study used a survey questionnaire to sample 250 respondents attending five private secondary schools in Gaborone, with a total population of 2500 students.

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YOUNG PEOPLE AND SEXUAL EXPERIENCE, PRACTICE AND BEHAVIOUR

HIV/AIDS seriously affects adolescents throughout the world. One third of all currently infected individuals are youths aged between 15 and 24 years and half of all new infections occur in youths of the same age (UNAIDS, 2001). According to UNAIDS (2000), about 1.7 million new adolescent infections – that is, over half of the world's total – occur in sub-Saharan Africa. The pandemic has had a devastating effect on most African youths who lack access to sexual health information and services, and in particular unmarried youth,, who have difficulties in accessing the needed services. At the same time cultural, social and economic norms and pressures often put young African women at greater risk of HIV infection (UNICEF *et al*. 2002).

Information about early sexual activity is of obvious value in defining the onset of potential exposure to various types of risk, such as HIV, STDs and unwanted pregnancies. The initiation of sexual intercourse early in life is associated with enhanced risk of HIV infection and STDs (WHO 1995; Ministry of Health (MOH), UNICEF Botswana, AYA, UNAIDS and PSI International, 2001) due to the length of sexual exposure, unless first sexual intercourse marks the beginning of mutually monogamous relationship. According to the WHO, cited in Carael (1995), there is a difference between African countries with regard to the proportions of never-married males and females aged between 15 and 19 years who reported sexual intercourse in that age group, ranging from less than 10 percent in Burundi to 69 percent in Guinea Bissau. Available data also show that sexual experience among young males ranges from 1 to 69 percent, and from 9 to 56 percent among young females in study populations (WHO, 1999). In all study populations the level of sexual experience is much higher among young men than young women (Carael, 1995).

The Ministry of Health *et al.* (2001) note that most young Batswana are more likely to engage in safer sex behaviour now than in the past. However, they still put themselves at risk by having many sexual partners; through sexual coercion; problems with condoms; and substance abuse. Besides these factors, some young people have fatalistic attitudes about AIDS, which may greatly influence their behaviour. One quarter of the boys studied agreed that acquiring AIDS is fate, as did 9.3 percent of girls. Those in rural areas or with lower levels of education were more likely to agree. It appears that the more youths are opting to delay the onset of sexual activity than did so in the past. Only 3.3 percent of young girls and 10.4 percent of young boys aged 13 and 14 had ever had sex. This rose to around two thirds of older males and females. By the age of 20, half of all males and females had had sex. For sexually active youths, the average age at first sexual intercourse was 17 years. Most of the youths in Botswana between the ages of 15 and 24 years had had a regular partner in the past, and over half of the males had had one casual partner as well, compared to a quarter of the females (Meekers 2001; MOH *et al*. 2001).

Generally teen sexual behaviour across sub-Saharan Africa starts at an early age. According to a 1998 survey in Africa, one third of girls aged between 15 and 19 have had premarital sex. The rate was as high as 72 percent in Liberia and 65 percent in Botswana. The overall percentage of sub-Saharan African young women up to the age of 24 who had had premarital sex was 61 percent, indicating that it is not a rare activity. It was also reported that by age 20, nearly all boys in the same age group are sexually active (UNFPA, 1999). Seloilwe, Mokoto, Letshaba, Veskov, Kobue, Bainame and Muzila (1999) note in their University of Botswana (UB) study that 94 percent of female students had had penetrative sex between the ages of 14 and 23 years. For male students, by the age of 14 years less than 13 percent had experienced sexual intercourse, with 96.5 percent being sexually active by the age of 23 years. This means that in Botswana youths are vulnerable to sexually transmitted diseases at an early age.

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With regard to condom use, the study by Seloilwe *et al.* (1999) of UB students shows that about 22 percent of males and 40 percent of females engage in unprotected sex. Of those who engaged in casual sex outside their current relationships, over a period of 5 years, 32 percent had used condoms occasionally or not at all. This is quite high considering the high prevalence rates of HIV and other STDs, and the level of knowledge university students are supposed to have. According to the MOH *et al.* (2001), though young people hold positive views about the need for condom use if sexually active, between 60 and 80 percent thought that it was unrealistic to use a condom every time. This implies that there may be no consistency in the use of condoms among the youth.

DATA ANALYSIS AND DISCUSSION

Age and Gender

TABLE 1
NUMBER OF RESPONDENTS SURVEYED BY AGE AND SEX

Age	Sex		
	Female	**Male**	**Total**
12-13 years	14 (29.8%)	33 (70.2%)	47 (18.8%)
14-15 years	41 (55.4%)	33 (44.6%)	74 (29.6%)
16-17 years	38 (51.4%)	36 (48.6%)	74 (29.6%)
18 and over	31 (36.4%)	24 (43.6%)	55 (22.0%)
TOTAL	**124 (49.6%)**	**126 (50.4%)**	**250 (100%)**

Table 1 shows the distribution of the respondents by age and sex. The respondents were generally in the age range of 12 to 18 years. Of the total number of respondents, 124 (49.6%) were females and 126 (50.4%) were males. The respondents distribution by age was as follows: 12 to 13 years, 47 (18.8%); 14 to 15 years, 74 (29.6%); 16 to 17 years, 74 (29.6%); and 18 years and older 55 (22%). The overall age distribution is typical of students in secondary schools in the country

Knowledge and Attitudes

UNICEF (2000) notes that two thirds of young people in Botswana, in their last years of primary school, thought that they could tell if someone is HIV positive by looking at him/her. Among secondary school students, a fifth of those surveyed still believed that they could screen risky partners by looking at them.

TABLE 2
NUMBER OF RESPONDENTS WHO INDICATED THAT THEY COULD KNOW BY APPEARANCE IF A PERSON IS HIV POSITIVE

	Female	**Male**	**Total**
Know by appearance if a person is HIV positive	Frequency and Percentage	Frequency and Percentage	Frequency and Percentage
Yes	44 (41.9%)	61 (58.1%)	105 (42%)
No	65 (52%)	60 (48%)	125 (50%)
I don't know	12 (60%)	8 (40%)	20 (8.0%)
Total	121 (48.4%)	129 (51.6%)	250 (100%)

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The respondent's ability to indicate whether or not it is possible to know by appearance if a person is HIV positive demonstrates awareness that looks can be deceptive, and that a healthy looking person can carry the AIDS virus. This then means all sexual encounters need to embrace non-risky behaviours through condom use. Identification of false levels of information amongst the respondents provides pointers as to the content and targeting of possible interventions to create the necessary conditions for change. When the respondents were asked whether they were able to tell by appearance if a person was HIV positive, 125 (50%) indicated that they would not be able to tell by appearance if a person was HIV positive, 105 (42%) stated that they were able to tell by appearance, and 20 (8%) of them did not know (Table 2). The 105 (42%) Yes responses and the 20 (8%) don't knows were regarded as not being aware of the fact that one cannot tell just by looking at the person whether or not she/he had the AIDS virus. The fact that just half of the respondents, 125 (50%), said they cannot tell by looks if a person is HIV positive indicates the gap in the awareness of knowledge among the respondents with respect to who may be infected, and how sexual intercourse with healthy looking persons without use of a condom may lead to infection.

From the data, and in relation to the findings of UNICEF (2000), the acceptance by half of the respondents that it is not possible to tell by appearance if a person is HIV positive (Table 2) represents a major achievement of the information campaign. It shows an improvement in knowledge among young people. However, the other half of the respondents still believe that it is possible to know by appearance that a person was HIV positive. This means that there is a higher chance that these respondents may put themselves at risk in the belief that they are able to screen HIV-positive people by merely looking at them. It may be concluded that there are still large gaps in knowledge and information. This is linked to the fact that a large number of youths are not aware that a healthy-looking person may be HIV positive.

The data indicate that many respondents know someone with AIDS. For example, more than half of the respondents, 137 (54.8%), personally knew someone who had AIDS or was infected with the virus; 103 (41.2%) indicated that they did not know anyone; and 10 (40%) were not sure (Table 3). This underscores the widespread nature of AIDS, despite the fact that there is no real openness about AIDS in the communities. Based on these data, there seems to be a huge leap from the findings of the MOH *et al*. (2001), which revealed that less than 6 percent of older youths were aware of someone who was HIV positive. Thus 65 (47.4%) female and 72 (52%) male respondents knew someone who was HIV positive or had AIDS. Again the data support the general knowledge that there is hardly any family or community that is not touched by HIV/AIDS. It may even be possible that some of the respondents assist in caring for those infected in their households based on the fact that most HIV/AIDS patients are cared for at home by relatives under the Community Home-Based Care programme.

TABLE 3
KNOWLEDGE OF A PERSON LIVING WITH HIV/AIDS

	Female	**Male**	**Total**
Do you know someone living with HIV/AIDS?	Frequency and percentage	Frequency and Percentage	Frequency and Percentage
Yes	65 (47.4%)	72 (52.6%)	137 (54.8%)
No	53 (51.5%)	50 (48.5%)	103 (41.2%)
I don't know	6 (60%)	4 (40%)	10 (4%)
Total	124 (49.6%)	126 (50.4%)	250 (100%)

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Condom Use

Condom provides dual protection, that is, against pregnancy and most sexually transmitted diseases (STDs), including HIV/AIDS. The need for condom use in Botswana is critical due to the rapid and widespread occurrence of AIDS in the country. This is because there is no vaccine for HIV/AIDS and, although treatments are improving, these are very expensive and there is no cure. Therefore, for the foreseeable future behaviour change, including widespread condom use, is a major way to curb the spread of the AIDS epidemic. Although not providing perfect "safe sex", a condom reduces the risk of individual infection substantially (UNAIDS, 2000). For example, according to the Population Report (1999), all cohort studies conducted in the United States through 1995 that evaluated condom use among heterosexual couples showed that consistent use protected against HIV. In some instances, effectiveness shows that infection rates were very low, less than 1 percent per year, among consistent condom users.

Whereas most youths are aware of condoms, there are misconceptions that appear to dissuade youths from using them. For example, a study of secondary school students in Nairobi and Homa Bay, Kenya, reports that awareness of condoms was not an issue. Most young people were aware of its role in preventing HIV transmission and could name several brands. This awareness was, however, countered by considerable mistrust of the condom. The students believe that since the virus is very small, it can go through the pores in a condom, hence making it unsafe. Some of the youths argued that a condom is risky because it is likely to remain in the vagina. Thus, only 35 percent of urban, and 56 percent of rural students (females and males), expressed confidence in the effectiveness of a condom (Nyamongo, 1995). Again in a case study of adolescents in Selebi Phikwe, Mahalapye and Kang in Botswana, 76 percent of adolescents argued that condom slides off, hence making it unsafe (Kgosidintsi, 1997).

Thus, most young people who have sex do not use condom. For example, in countries of sub-Saharan Africa that were surveyed, the percentage of unmarried sexually active women between the ages of 15-29 who reported using a condom in their most recent sexual encounter ranged from 2 to 8 percent (UNAIDS, 2000).

To ascertain the sexual communication patterns of respondents, they were asked whether they could request a partner to use a condom. An overwhelming majority of the respondents (221 - 88.4%) answered in the affirmative while only 29 (11.6%) indicated that they could not ask their partner to use a condom. Of those who said that they would not be able to do so, 14 (48.3%) were between the of ages 12 and 13 years, 7 (24%) were between 14 and 15 years, 4 (13.8%) were between 16 and 17 years, while 4 (13.8%) were 18 and over. The respondents were further asked about their ability to request both steady and casual partners to use condom. There was a higher percentage of respondents who would be able to ask a casual partner to use a condom, 224 (89.6%) as compared to 202 (80.8%) respondents who would be able to ask a steady partner to use a condom. This means that there is a higher chance of condom negotiation with both casual and steady partners (Tables 4a & b).

One of the demographic factors associated with AIDS risk behaviour is gender. Before the introduction of the female condom, males could not ask their female partners to use a condom, since they were the only ones who, technically, had the responsibility. However, the notion that condom use is a man's prerogative is no longer valid. Thus, although the study did not ask males specifically about the female condom, there was still an interest in knowing if males could ask their partners to use a condom. Table 4a indicates that of the 221 (88.4%) respondents who said that they could ask their partner to use a condom, 112 (50.7%) were females and 109 (49.3%) were males. However, of the 24 (9.6%) who said that they could not ask their partners to use a

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condom, 10 (41.7%) were females and 14 (58.3%) were males. The data reveal that there are more females than males who could ask their partners to use condoms. This may be an indication that the idea of condom use is still tied to males. The female condom is still not as widely known and distributed as the male condom, and it is relatively more expensive.

TABLE 4a
NUMBER OF RESPONDENTS INDICATING ABILITY TO ASK THEIR PARTNER TO USE A CONDOM (CASUAL OR STEADY) BY GENDER

	Female	**Male**	**Total**
Would you ask your partner to use a condom?	Frequency and Percentage	Frequency and Percentage	Frequency and Percentage
Yes	112 (50.7%)	109 (49.3%)	221 (88.4%)
No	10 (41.7%)	14 (58.3%)	24 (9.6%)
Missing	2 (40%)	3 (60%)	5 (2.0%)
Would you be able to ask a steady partner to use a condom?			
Yes	99 (49%)	103 (51%)	202 (80.8%)
No	21 (53.8%)	18 (46.2%)	39 (15.6%)
Missing	4 (44.4%)	5 (55.6%)	9 (3.6%)
Would you be able to ask a casual partner to use a condom?			
Yes	110 (49.1%)	114 (50.9%)	224 (89.6%)
No	11 (61.1%)	7 (38.9%)	18 (7.2%)
Missing	3 (37.5%)	5 (62.5%)	8 (3.2%)

TABLE 4b
NUMBER OF RESPONDENTS INDICATING ABILITY TO ASK THEIR PARTNER TO USE A CONDOM (CASUAL OR STEADY) BY AGE

Variable	**AGE**				**Total**
Ability to ask a partner to use condoms	Frequency 12-13	Frequency 14-15	Frequency 16-17	Frequency 18 and over	Frequency
Yes	33 (15.5%)	67 (30.3%)	70 (31.7%)	51 (23.1%)	221 (88.4%)
No	14 (48.3%)	7 (24.1%)	4 (13.8%)	4 (13.8%)	29 (11.6%)
Ability to ask a casual partner to use condoms					
Yes	41 (18.3%)	68 (30.4%)	66 (29.5%)	49 (21.9%)	224 (89.6%)
No	6 (23.1%)	6 (23.1%)	8 (30.8%)	6 (23.1%)	26 (10.4%)

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However, of the 202 (80.8%) respondents who could ask their steady partners to use a condom, there were more males, 103 (51%), than females, 99 (49%). Of 39 (15.6%) respondents who could not ask a steady partner to use a condom, 18 (46.2%) were males and 21 (53.8%) were females. This trend carries through to the 224 (89.6%) respondents who stated that they could ask their casual partner to use condom. Of this number, 110 (49.1%) were females and 114 (50.9%) were males. There were slightly more females than males who could not ask their casual partners to use a condom (Table 4a). This may be an indication that, on average, male respondents are able to negotiate for greater condom use than female respondents. This may also be explained by power imbalances between males and females even at this age due to socialisation in the context of patriarchal relations.

Attitudes towards condom use

TABLE 5
LIKELIHOOD OF CONDOM USE WITH STEADY AND CASUAL PARTNERS BY GENDER

	Female	**Male**	**Total**
Use condoms with steady partner	Frequency and Percentage	Frequency and Percentage	Frequency and Percentage
Always	96 (52.2%)	88 (47.8%)	184 (73.6%)
Half the time	5 (26.3%)	14 (73.7%)	19 (7.6%)
Less than half	4 (36.4%)	7 (63.6%)	11 (4.4%)
Never	19 (52.8%)	17 (47.2%)	36 (14.4%)
Use of Condoms with casual partners			
Always	80 (50%)	80 (50%)	160 (64%)
Half the time	9 (39.1%)	14 (60.9%)	23 (9.2%)
Less than half	7 (36.8%)	12 (63.2%)	19 (7.6%)
Never	28 (58.3%)	20 (41.7%)	48 (19.2%)
Frequency of condom use by those who have partners			
Always	90 (52.3%)	82 (47.7%)	172 (68.8%)
Half the time	34 (50%)	34 (50%)	68 (27.2%)
Less than half	1 (50%)	1 (50%)	2 (0.8%)
Never	6 (54.5%)	5 (45.5%)	11 (4.4%)

Table 5 gives a summary of the likelihood of condoms being used by the respondents. The data reveal positive attitudes towards condom use by the respondents. For instance, 184 (73.4%) respondents said that they were likely to use a condom always with steady partners, with 160 (64%) indicating likewise with casual partners. Again 172 (68.8%) respondents who have partners use a condom always. Overall, the data have positive health implications. However, it is also clear that many respondents engage in behaviours that increase their risk of HIV infection. Of the respondents who have steady partners, 68 (27.2%) use condom half of the time, 81(32.4%) said that they always use a condom when they have sex, 2 (0.8%) use one less than half the time, and 11 (4.4%) never use a condom when they have sex.

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The respondents were asked how comfortable they would feel using a condom (Table 6). The majority, (151 - 60.4%) indicated that they would feel very comfortable. However, a large number (85 - 34.0%) of respondents would feel very uncomfortable and 14 (5.6%) did not respond. A large majority of respondents (199 - 79.6%) would be very comfortable asking a partner to use a condom, but 35 (14%) would be very uncomfortable. The respondents were also asked how comfortable they would feel about having sex with a new partner. The majority 155 (62%) indicated that they would feel quite uncomfortable about it, while 76 (30.4%) said that they would be comfortable. Of those who said that they would be very uncomfortable having sex with a new partner, 22 (14.2%) were between 12 and 13 years, 58 (37.4%) between 14 and 15 years, 45 (29%) between 16 and 17 years, and 30 (19.4%) were 18 and above (table not shown). The data from Table 6 reveal that female respondents (90 - 58.1%) would be more uncomfortable about having sex with a new partner than the male respondents (65 - 41.9%). Of the 76 respondents who had indicated that they would be quite comfortable having sex with a new partner, 23 (30.3%) were females while 53 (69.7%) were males.

This may be explained partly by the differences in male and female socialisation and the fact that in many African cultures males are expected to initiate and control sexual activities, while females are expected to be submissive and passive. Also the large number of youths who would be comfortable having sex with a new partner is an indication of some of the casual cultural attitudes towards sex, especially on the part of males who must be seen to have the ability not only to initiate sex but also to produce children, and of the fact that many youths develop their ability to handle sexual relations early.

TABLE 6
COMFORT LEVEL OF RESPONDENTS IN CERTAIN SITUATIONS

	Female	**Male**	**Total**
How comfortable would the respondents be using a condom?	Frequency	Frequency	Frequency
Very comfortable	77 (51%)	74 (49%)	151 (60.4%)
Very uncomfortable	37 (43.5%)	48 (56.5%)	85 (34.0%)
Missing	10 (71.4%)	4 (28.6%)	14 (5.6%)
How comfortable would the respondents be asking a partner to use a condom?			
Very comfortable	101 (50.8%)	97 (49.2%)	199 (79.6)
Very uncomfortable	14 (40%)	21 (60%)	35 (14%)
Missing	9 (56.3%)	7 (43.8%)	16 (6.4%)
How comfortable would the respondents be having sex with a new partner?			
Very comfortable	23 (30.3%)	53 (69.3%)	76 (30.4%)
Very uncomfortable	90 (58.1%)	65 (41.9%)	155 (62%)
Missing	11 (61.1%)	8 (44.4%)	18 (7.6%)

The 138 respondents who had partners were asked about circumstances under which they would use a condom. Thirty two (23.2%) indicated that they would use a condom only when they did not trust their partner, 17 (12.3%) would use it in a new relationship, 53 (38.4%) would do so as long as they were not married, and only 11 (8%) stated that they would use a condom whenever they

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had sexual intercourse (Table 7). This reveals that, though most respondents said that they always use condoms, closer examination shows that young people may not use a condom in every sexual encounter. For example, only a slight majority would use a condom as long as they were not in a marital relationship, and a very small number will use it whenever they have sex. Generally, condom use among the youth has not reach such a high level as to make it uphold its reputation as an effective method against HIV/AIDS infection in Botswana. This, unfortunately, is one of the major reasons why the infection rates continue to be very high in the country.

TABLE 7
RESPONDENTS WHO HAVE PARTNERS, AND CONDOM USE.

	Female	**Male**	**Total**
Do you have a partner?	Frequency	Frequency	Frequency
Yes	76 (55.1%)	62 (44.9%)	138 (55.2%)
No	41 (40.2%)	61 (59.8%)	108 (40.8%)
Missing	4 (44.4%)	5 (55.6%)	9 (3.6%)
Have you used a condom with your partner?			
Yes	51 (50.5%)	50 (49.5%)	101 (73.2%)
No	25 (67.6%)	12 (32.4%)	37 (26.8%)
Under what circumstances would you use a condom?			
When you don't trust your partner	14 (43.8%)	18 (56.3%)	32 (23.2%)
In a new relationship	7 (41.2%)	10 (58.8%)	17 (12.3%)
As long as I am not married	32 (60.4%)	21 (39.6%)	53 (38.4%)
Whenever I have sex	7 (63.6%)	4 (36.4%)	11 (8%)
Missing	16 (64%)	9 (36%)	25 (18%)
How often did you use a condom with your partner?			
Every time	43 (55.8%)	34 (44.2%)	77 (55.8%)
Sometimes	10 (4.2%)	14 (58.3%)	24 (17.4%)
Never	23 (62.2%)	15 (40.5%)	37 (26.8%)

DISCUSSION

Likelihood of condom being used

The data reveal a high likelihood of a condom being used with both casual and steady partners, hence underlining a positive trend in condom use. This may imply an increase in the ability of young people to negotiate for safer sexual practices. There seems to be a negative correlation between age and safe sex practice negotiation. Of the respondents who indicated that they would not be able to ask their steady partners to use a condom, the majority (66.7%) were between the ages of 12 and 15 years. The inability of young people in this age group to ask partners to use condoms may be due to lack of experience in sexual relationships and also of the skills that are necessary for negotiation. Age difference may interact with gender inequalities and other social

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factors to determine the extent of young people's vulnerability to STDs, including HIV. This is the case of younger women who may be sought as sexual partners by older men in the belief that they are less likely to be infected. For these young females, their ability to negotiate for safer sex practices such as condom use may be somewhat limited, not only because of their undeveloped negotiation skills but also their dependence on these older men for financial and other kinds of support. Culture also makes women subservient to men. Thus, both young men and women are vulnerable, not only those who sell or trade sex, but also those who engage in sexual activity as a means of gaining adult status and the privileges it offers (Carael, 1995).

Interestingly, slightly more female respondents (112 - 90.3%) than their male counterparts (109 - 86.5%) were more willing to ask their partners to use a condom. However, careful analysis of asking causal and steady partners to use a condom reveals a contradiction, namely that there are more male respondents who could ask their partners, casual (114 - 50.9%) and steady (103 - 51%) to use a condom than their female counterparts – casual (110 - 49.1%) and steady (99 - 49%). This may mean that female respondents were not entirely truthful in their responses about their ability to ask partners to use condoms. In many instances females may not have the power either to avoid unprotected sex or to ensure the use of condoms. Gender inequalities and socialisation with respect to male/female behaviour in sexual matters ensure that females usually have little say in sexual relations.

The data reveal that young males are more comfortable with their sexual partners than young females. This indicates a marked difference in sexual power relations among young people, with males having more power in sexual relations than females. The emphasis and pressure on females to act innocent in sexual matters prevent young females from being free about their sexuality. This also hampers them from asking for information about sex or services relating to their sexual health. Culturally, sexually active females are also discouraged from discussing sex too openly with their partners. Thus, young women are unlikely to be able to communicate their need for safer sex with partners. Studies from other African societies also support this view. For example, a Kenyan study revealed that young women felt that they did not have control over their sexuality. Instead, girls learnt that sex was something that happened to them. It was not something they could initiate or actively participate in (Rivers & Aggleton, 2001).

In addition to the emphasis widely placed on remaining "chaste," girls are commonly socialised to be submissive to men. Girls report often being pressured by boys to have sex as a proof of love and obedience. Not surprisingly, under conflicting pressures, girls have little influence over decision making or the use of contraception. Where sexually active young women are aware of HIV/AIDS and measures to protect against infection, they rarely have the power to ensure that condom is used. This also brings up the issue of negotiating for safer sex practices, because the less power people have over their sexual practices, the higher the chances that their capacity to negotiate is greatly diminished. While gender norms dictate that girls and women should remain poorly informed about sex, young men are expected to be knowledgeable, often as an indication of their maturity. The tragedy is that, while young women risk their sexual health because they must appear to be ignorant and so cannot openly seek information, young men risk their sexual health because they must appear to be knowledgeable and experienced. Thus, they may also be reluctant to seek information.

Consistency of condom use

The data indicate that there is a high awareness of the relationship between certain behaviours and HIV infection. However, a high level of awareness of risk for many young people is not enough to encourage a change in sexual behaviour. There is a need to look at other factors that come into

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play, such as boys trying to prove their virility by having multiple sexual partners; the ability to negotiate for condom use; and correct use of a condom. It is evident from the data that a high level of awareness of condom is not necessarily accompanied by widespread use. This means that there are inconsistencies in condom use, varying from whether or not the person trusts a partner to a length of the relationship. While the data suggest that sexual intercourse is common among the youth, inconsistent use or non-use of condom places them at risk of STDs and HIV infection. There seems to be no marked difference in consistency of condom use among males and females.

The inconsistent of use a condom, or the complete non-use of a condom in any sexual encounter by youths means that programmes on HIV/AIDS must be intensified. Sex education must therefore be comprehensive, "...highly participatory, reflexive and challenging", and must lead to "...increased self-esteem and self-efficacy, increased motivation and to actual skill development regarding sex and relationship. This is essential for both boys and girls, but with the emphasis for girls on self-empowerment and on boys to share responsibility" (Jackson, 2002:130-131). Given the current trends of HIV infection, intensified health education is absolutely necessary.

RECOMMENDATIONS

It is clear from the data that intentions alone are not enough to predict condom use in sexual encounters and avoidance of sexual risk behaviour. For example, for the actual positive behaviour (use of a condom) to occur, it is argued that certain other conditions have to be fulfilled, including knowledge of the proper use of condoms, availability of condoms, and an agreement with a partner to use them. This raises the critical issue of communication with one's sexual partner. This is not an easy task, especially, for youths brought up in cultures where discussion of sexual matters is, or has been, a taboo.

It is recommended that the AIDS education programmes by schools and NGOs such as the Botswana National Youth Council (BNYC), Botswana Family Welfare Association (BOFWA), Population Services International (PSI), and YWCA/PACT (Peer Approach to Counselling by Teens) and the Youth Health Organisation (YOHO) be strengthened and expanded to all levels of the educational system. The youth must have access to reproductive information and other materials on sexuality, backed by unhindered access to youth-friendly health care services and other related programmes.

In addition, sex education should emphasise measures to discourage both boys and girls from engaging in sex early in life or from having sex altogether. This means that efforts should be directed towards developing the social competencies of youths with respect to self-assertiveness, interpersonal negotiating skills, self-esteem and personal responsibility. All these are related to social empowerment and the ability to make decisions that are life enhancing and promote positive sexual behaviour. The focus on sex education and life-skills development must also emphasise sexual behaviour change among youths who are already sexually active, and maintenance of non-risk behaviours including delaying the onset of sexual activity by those not yet active. Thus, sex education should creatively combine both technical aspects and strengthening of moral standards. The youth need to understand that they do not have to engage in sex to 'fit in'; that sex can be enjoyed without risks; and that condom use enhances the chances of avoiding risks.

Through the Parent Teacher Associations (PTAs) in schools, parents can also play significant roles in strengthening and ensuring that moral education of their children takes place to complement other educational programmes by schools, youth NGOs and the media. Thus, AIDS education, counselling and health programmes must deal with young people's ability to adhere to positive behaviour in sexual relationships, negotiate for condom use, delay the onset of sexual activity,

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access necessary materials and services, and be assertive in interpersonal relations and communications.

CONCLUSION

In general young people have more knowledge and positive attitudes towards precautionary measures against AIDS. However, many are unlikely to adhere to precautions and therefore undertake risky behaviour. Though Botswana youths have learnt to live with the condom, they also believe that a condom might limit sexual pleasure, and hence would be more likely not to use it all the time. The data also show the importance of contextual factors such as culture that come into play in non-precautionary behaviour among Botswana youth, for instance, the emphasis on so-called innocence, which prevents young females from being free about their sexuality and from seeking related information and services.

Even though knowledge levels seem to be high, knowledge and behaviours (safe sex) appear to be unrelated. For example, in this study, the data show that greater knowledge does not necessarily lead to safer sex practices. Also findings in earlier studies reveal that knowing that condom prevents transmission of the HI virus does not result in greater intention to use condoms, nor does this knowledge lead to an actual increase in condom use. There is also a marked discrepancy between knowledge and performance of safe sexual behaviours, as measured by questions about condom use in sexual encounters. The attitude and conduct of youths regarding sexuality and safe sex practices and precautionary behaviours are such that efforts at sex education, developing social and interpersonal competencies, and enhancing personal responsibility must be emphasised and related activities strengthened.

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