Running head: BOTSWANA

An evidence-based review on the importance of self-management skills for successful HIV/AIDS prevention programs: University of Botswana

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TABLE OF CONTENTS

Abstract

Problem Statement

Purpose

Conceptual Framework

Literature Review

Implementation of Self-Management Skills

Significance to Nursing

Need for Further Research

Conclusion

LIST OF TABLES

Table 1 - Regional HIV and AIDS statistics, 2001 and 2007.................................5

Table 2 – Instructor’s Guide to Managing Everyday Problems...............................19-20

LIST OF FIGURES

Figure 1 - HIV prevalence globally and in sub-Saharan Africa..............................5

Figure 2 - Percent of adults (15+) living with HIV who are female........................6

Figure 3 - Median HIV prevalence among women (15–49 years) attending antenatal
clinics in consistent sites in southern African countries.................................7
Abstract

Currently 33.2 million people worldwide live with Human Immunodeficiency Virus (HIV) and/or Acquired Immunodeficiency Syndrome (AIDS); 25 million of these live in sub-Saharan Africa. Due to their sexually risky behaviors, one of the highest risk groups for HIV in sub-Saharan Africa is college-aged students. However, statistics do not usually address this population specifically. Although research in the United States has identified the success of specific interventions that have decreased sexually risky behavior specifically in middle and high school aged young people, there has been some successful work with college-aged students as well. However, there has been little effort devoted to making the programs already shown successful in the United States culturally appropriate for other countries. One of the major researchers of the programs shown to be effective in the United States is Douglas Kirby. This article examines the usefulness of Douglas Kirby’s Logic Model in creating interventions appropriate for the college-aged students in sub-Saharan Africa. It will review programs Kirby found effective in the United States for middle and high school youth as well as the possible incorporation of self-management skills that have been shown effective in college-aged students in the United States.
Problem Statement

In the last statistical analysis of the Joint United Nations Programme on HIV/AIDS (UNAIDS) conducted in December of 2007, 33.2 million people worldwide were living with HIV/AIDS. Of this alarming rate, 68% of the affected lived in sub-Saharan Africa (UNAIDS, 2007).

Table 1. Regional HIV/AIDS Statistics, 2001 and 2007 (UNAIDS, 2007)

<table>
<thead>
<tr>
<th></th>
<th>Adults and children living with HIV</th>
<th>Adults and children newly infected with HIV</th>
<th>Adult prevalence (%)</th>
<th>Adult and child deaths due to AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>2007</td>
<td>20.9 million (19.7 million-23.6 million)</td>
<td>22.5 million (20.9 million-24.3 million)</td>
<td>1.7 million (1.4 million-2.4 million)</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>2001</td>
<td>20.9 million (19.7 million-23.6 million)</td>
<td>2.2 million (1.7 million-2.7 million)</td>
<td>5.8% (5.5%-6.6%)</td>
</tr>
</tbody>
</table>

This region also accounts for the largest number of AIDS-related deaths in the world: 76% in 2007. Thirty-two percent of all new HIV infections occur in sub-Saharan Africa particularly in Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe (UNAIDS, 2007).

Figure 1. Estimated adult (15-19) HIV prevalence (%) globally and in sub-Saharan Africa 1990-2007 (UNAIDS, 2007)
Statistics in some African countries are inconclusive in regards to questions centered on safe sex and the incidence of having sexually active relationships with non-regular partners. For some countries, especially Kenya and Zimbabwe, the rates of young people engaging in sexual activities with non-regular partners have decreased. However, close to two dozen of the 35 countries have insufficient data on HIV prevalence and/or sexual behavior trends in young people. Concrete data on HIV prevalence rates and information on sexual behaviors in some highly infected southern African countries do not exist at all (UNAIDS, 2007).

There has been a dramatic increase as a direct result of a gender shift in the spread of HIV/AIDS. There has been a significant increase in female contraction of the disease from men. As of 2007, women accounted for 15.4 million cases of HIV/AIDS and men accounted for 13.7 million (UNAIDS, 2007). In sub-Saharan Africa, almost 61% of adults living with the disease were women (UNAIDS, 2007). The United Nations Development Fund for Women [UNIFEM] found a 15% prevalence rate of HIV in 15-19 year old girls and only a 1.2% rate for boys in the same age group (2007).

Figure 2. Percent of Adult (15+) living with HIV who are female 1990-2007 (UNAIDS, 2007).
Culturally, young women are at a disadvantage in Africa. Many are victims of "survival sex" and sexual violence (UNAIDS, 2002). Many Africans believe in "widow cleansing," in which widowed women are forced to have sex with others in efforts to "cleanse" themselves of their husband's passing. Also, many African communities still participate in female genital mutilation and early childhood marriage. Young, sexually active girls are much more vulnerable to contracting sexually transmitted diseases because of their immature genito-urinary systems. Another reason leading to young women's vulnerability to contracting HIV is economics: women have much less earning power and fewer legal rights than men (Whitehead, 2003; Global Coalition, 2004). Therefore, these cultural realities for African women contribute to an increased risk for HIV/AIDS.

One particular southern African country, Botswana, has seen a decrease in HIV prevalence among pregnant women attending antenatal clinics. An alarming rate of 36% in 2001, a slight decline to 32% was seen in 2006. For women between 20-24 years of age, the prevalence rate dropped dramatically from 39% in 2001 to 29% in 2006 (UNAIDS, 2007). Of note is a significant decrease in Botswana. This decrease is positive, but serious concerns remain.
In Botswana, HIV prevalence rates not specific to young pregnant women were between 36-40% (UNAIDS, 2007). Prevalence rates at the university level alone were 40% (Seloiwe, Jack, Letshabo, Balname, Veskov, & Mokotos, 2001). It is especially important to emphasize the importance of healthy sexual decision-making skills in the college-aged population. It is hoped that by implementing interventions at the university level, young African adults will acquire the appropriate skills to prevent the spread of this disease and empower them to change the future.

Preliminary research conducted by Brown, Sebego, Seboni, Ntsayagae, Mogobe, & Sabone at the University of Botswana (2006) found five major difficulties in helping students lessen their sexually risky behaviors. First, the students are vulnerable to HIV/AIDS simply due to cultural barriers. Second, many young people do not have the resources to help them make positive sexual decisions. Third, students lack communication skills, particularly refusal skills for young women and reflective listening skills for men. Fourth, self-management relating to alcohol use and sexual behaviors are
difficult for this age group. Lastly, although efforts have been made to educate young people about basic knowledge of condom application and general sex education, these programs are still scarce (Brown, et al., 2006). Of these five major difficulties, the one to be addressed in this paper is the inclusion of self-management skills in intervention programs whose purpose is to decrease sexually risky behaviors in young Batswana students.

Purpose

The objective of this article is three-fold: 1) to review evidence on the effectiveness of prevention programs proven to be successful in decreasing sexually transmitted diseases in adolescents, 2) to examine the importance of increasing the programs effectiveness by adding the self-management skills shown to be effective in college-aged students, and 3) to suggest ways of making such an intervention appropriate for HIV/AIDS prevention programs for college-aged students at the University of Botswana. The importance of these objectives is highlighted by investigating the history of HIV/AIDS infections and attempts at prevention at the University of Botswana. Recent research shows a 40% HIV positive rate at the university (Seloiwe, et al., 2001). In 2004, an educational course was developed and implemented at the university. Although students claimed better knowledge of HIV/AIDS as a result of the course, there was minimal change in sexually risky behaviors (Brown, et al., 2006). It is hoped that by adapting self-management programs shown to be effective in decreasing sexually risky behavior in young people in the United States to the Botswana culture, the rate of such risky behaviors in Batswana youth will lessen as it has in the United States.
Conceptual Framework

Douglas Kirby’s Logic Model (2001) will serve as a framework for this paper. The logic model is defined by three key components: 1) the behaviors to be changed, 2) the precursors of these behaviors, and 3) the particular program activities designed to change these precursors. Carefully planned programs with clear, concise, and orderly goals proved to produce the best outcomes (Kirby, 2001). Kirby’s model provides guidance for creating and adapting culturally specific interventions to decrease sexually risky behavior in young university students in Botswana.

Literature Review

In the early 1990s, the United States faced a significant increase in adolescent sexual activity. Teen pregnancy rates were 117 per 1,000 girls among 15-19 year olds. Kirby conducted a meta-review of the literature and evaluated 250 studies that reviewed the effectiveness of various interventions geared towards changing sexually risky behavior. His report, No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy (2001), reviewed more than 100 precursors or “antecedents” that lead to early teen sexual intercourse, poor contraceptive use, pregnancy, and childbearing (Kirby, 2001).

Kirby’s research was an intimate view of both the risk and protective factors that lead to risky sexual behaviors in young people in the United States. The research indicated a variety of factors, including relationships among communities, families, peers, and partners. Other factors that lead to risky behaviors are the adolescents’ individual personalities, socio-economic structures, attachment and belonging characteristics, emotional distress, and sexual beliefs and attitudes (Kirby, 2001). Kirby’s
findings served as the foundation for his updated report, *Emerging Answers* (Kirby, 2001). Although the research was conducted in the United States, some direct parallels may be useful when implementing a prevention program in the Botswana culture.

Specific pieces of Kirby’s research identified 43 contributing factors that were particularly significant. Some main highlights from his findings include: 1) community disadvantages such as low levels of education, employment, and income; 2) disorganization in society and an increase in crime rates; 3) levels of education in the family as a whole; 4) family structure (two parents vs. one); 5) family dynamics and attachment; 6) family values about sexual behavior and contraceptive use; and 7) peers’ norms and behavior on sexual decision making. In addition, age, hormone levels, attachment to school, engagement in other risky behaviors, emotional well-being, characteristics of their romantic relationships, past history of sexual abuse, sexual beliefs, attitudes, skills and motivations all directly affect the individual’s sexual behavior and contraceptive use (Kirby, 2001).

Social norms and connectedness to others are also major contributing factors in reducing risky sexual behavior. A simple example Kirby used to illustrate this point is cigarette smoking. If an adolescent surrounds him/herself with others who smoke, they are more likely to smoke. The same example can be used with sexual behaviors. Adolescents identify themselves with their peers. The more closely connected the teen is to his/her group, the greater influence the group’s social norms will have on the adolescent. This theory of social development posits a relationship between connectedness to a group and the impact of that particular group’s norms on the individual (Kirby, 2001).
Kirby discussed the extent to which these contributing factors influence the
development of any intervention/prevention program. He specifically described the
difficulty of attempting to address each of these issues in any one program (Kirby, 2001).
However, effective programs must examine multiple contributing factors to create a
clear, concise, and purposeful intervention program (Kirby, 2001). Although his main
studies specifically examined teen pregnancy, these findings can be adapted to other
populations (teens to adults) and to a variety of programs (STD, HIV prevention, and
contraception use).

Kirby’s research found the reasons for sexually risky behaviors were not always
directly related to the act of sex. Nonsexual antecedents such as sexual attitudes, beliefs,
skills, family, community, culture, and individual factors directly influence sexual
behaviors. The most influential nonsexual antecedents are more directly linked to the
socio-economic status of the individual’s community, family attachment issues,
success/failure in school, and one’s own psychological well-being (Kirby, 2001).
Therefore, it is important to create an intervention program that focuses on both sexual
and nonsexual antecedents.

When formulating an intervention program focusing on sexual antecedents,
curricula in the United States vary among programs that focus on abstinence and those
that focus on sex or HIV education. Very little evaluation has been done on abstinence-only
programs. Only three studies met the criteria when Kirby conducted his meta-
analysis. Evidence of the effectiveness of these programs were deemed inconclusive by
Kirby and proved to have little effect on decreasing sexually risky behavior.
On the other hand, sex and HIV education programs have proven to have a positive effect on decreasing sexually risky behaviors. Some argue educational programs could be viewed as promoting sex at an early age by placing an emphasis on education and not abstinence. Kirby found that sex and HIV educational programs do not increase sexual activity. Educational programs do not increase the frequency of sex, do not increase the number of sexual partners, and do not hasten the onset of sex. In fact, several programs implementing sex and HIV education have successfully contributed to delayed sex, increased condom and other contraceptive use, and decreased unprotected sexual behaviors (Kirby, 2001).

Nonsexual antecedent programs focus on concepts beyond the act of sex itself. Programs of this nature examine other factors which may lead to pregnancy including disadvantaged families and communities, detachment from school and work, and the lack of close relationships with family and friends. Programs that focus on nonsexual antecedents have made strong efforts to help adolescents develop skills and confidence, focus on education, and pursue job opportunities. With nonsexual antecedent programs, adolescents are creating a responsible environment for themselves and are able to make healthy sexual decisions (Kirby, 2001).

Kirby’s final conclusion in *Emerging Answers* identified the three most helpful approaches in creating successful strategies. The best approach is to specially replicate and copy programs which have been proven to be effective. The second best approach is to select or design programs with common characteristics. If neither approach is used, adopting effective strategies and the use of similar logic models can act as a good starting point (Kirby, 2001).
Safer Choices, a program evaluated by Kirby, has a multi-component design. Safer Choices aims to reduce the number of students participating in unprotected sex in the high school population. Condom use, education on HIV and STD information, and other modifications to sexually risky behaviors are the primary focuses of this program. Based on a social cognitive theory and social influence theory, Safer Choices focuses on a school wide, adolescent, and community population based change. Utilizing Kirby’s findings, Safer Choices combines both sexual and nonsexual antecedent approaches in their intervention program (Coyle, Basen-Engquist, Kirby, Parcel, Banspach, Harrist, Baumler, & Weil, 1999).

The application of Kirby’s research findings on prevention programs has successfully decreased the rate of teen pregnancy in the United States by 28% and maintains a constant rate of 84 per 1,000 today (Henshaw, 2004). In Botswana, research has not been conducted on intervention programs developed from Kirby’s meta-analyses. In fact, there are very few sexual education or HIV prevention programs available to the college-aged student in Botswana. Healthy and safe sexual decision-making methods which have proven to be successful in the United States are not culturally adapted for the students at the University of Botswana. Additionally, most behavior research has focused on the early teenage group; very little research has been conducted at the university level (Brown, et al., 2006). For these reasons, creating a successful and culturally adaptable program would be invaluable for the University of Botswana.

Implementation of Self-Management Skills

The preliminary research by Brown and colleagues found five major points that must be addressed for any prevention program to be successful in the Batswana college-
aged population (Brown et al., 2006). The five major points can be directly related to Kirby's analyses. Both Brown et al. and Kirby's research explain the reasons why the University of Botswana students may have difficulties making healthy sexual decisions. Access to health care, education, HIV treatment and management is extremely difficult to obtain in Botswana. As a direct result of an undeveloped economic system, the students have limited access to the resources that can help them change their risky behaviors.

Perhaps the most significant data are the low rates of condom use and safe sex practices in sub-Saharan Africa. Even with the push for public education and knowledge on serious diseases like HIV/AIDS, sexually active people are still choosing not to use safety precautions. In some African countries, condom use is as low as 10-15% (Bankole & Singh, 2001). The low condom use in Africa can be viewed as an accepted societal, group, and cultural norm.

As Kirby concluded with his research in the United States, social connectedness within the African society may explain the lack of condom use and unsafe sexual practices. This concept is very important to acknowledge when creating an intervention program. Social norms and "group think" can affect the outcome of a prevention program. It is difficult to bypass the idea of social norms, but the ability to make independent decisions is very important to consider with behavioral changes. Self-management is one particular strategy that may help an individual begin the process of independent decision-making. For the purpose of this paper, self-management as it directly affects HIV/AIDS prevention for the university level will be reviewed in detail.

Self-management is the act of handling, controlling, and monitoring one's own independent actions. Brigham (1989) stated that self-management "requires not only the
ability to emit a particular response or set of responses but also the ability to discriminate and analyze behavior-environment interactions to determine which set of responses is appropriate for the particular situation” (pp. 16). A very important aspect of self-management is that it focuses on each individual and provides him/her a basis for understanding their own behavior(s) (Brigham, 1989). Another key objective of self-management is the ability of individuals to create situations in which they must work through their behaviors and identify potential problems. It is necessary to effectively teach concepts and procedures to provide the foundation for individuals to be successful in their own efforts (Brigham, 1989).

Brigham (1989) also discussed the importance of “increasing the probability of incompatible behaviors” (pp. 19). Many programs have focused on stopping a certain act, as the act is deemed to be “bad”. Instead, Brigham advocated for the opposite in that programs should emphasize good behaviors. He used the example of condom use in his training manual, *Self-management for Adolescents: A Skills Training Program*. The actual act of using condoms or other contraceptive devices cannot be implemented simply through an educational experience or an authoritative process. The decision to use a condom and to practice safe sex is influenced by multiple factors. Therefore, those factors must be analyzed to fully understand their complexity (Brigham, 1989).

Perhaps the simplest way of understanding self-management as Brigham (1989) explains, is the actual application of “behavior analysis principles and procedures to modify the behavior-environment interactions of the individual by the individual” (pp. 42). Self-control and reinforcement (whether they are positive or negative) affects motivation for self-management behaviors. If negative reinforcement results from an
environmental stimulus, a person is less likely to change their behaviors. For example, if condom use is rejected by peers in the African college community, an individual is less likely to use contraception. Self-managed individuals have the ability to change their own behaviors regardless of external stimulus. Brigham (1989) went on to explain that the majority of people who have difficulties with self-management lack the skills to help them make sound decisions. Thus, it is important to help individuals create self-management skills that will prevail even under the strongest and most difficult environmental influences.

This leads into the single most important component of self-management in changing behavior – reinforcement. Brigham (1989) explained the importance of analyzing the external environment and learning how to “discriminate” between appropriate and inappropriate actions. Good responses must be reinforced and self-managers need to have the skill to continue the behavior, especially when it produces a positive reaction. For the Batswana students, the first process of a self-management program should be an internal analysis of their own behavior-environment and its effects on their health (especially sexual health). It is necessary for students to look at their own sexual behaviors and analyze what the consequences would be if they participate in risky behaviors. Without a true perspective on the students’ cultural sexual practices, we cannot expect to change their behaviors.

Self-observation is similar to the component of reinforcement. The ability to observe one’s own behaviors in comparison to those around him/her is an intricate part of self-management. Self-observation helps the individual find appropriate responses and skills to implement self-management. It is especially important when individuals
recognize their influence and how their behaviors affect the environment. Lastly, it is important to analyze the environments reactions to self-managed individuals (Brigham, 1989). Self-observation may be extremely difficult for the students because they are affected by their sense of community and their connectedness to their culture.

The final analytical skill Brigham (1989) discussed is the matter of "personal private events" (pp. 44). If individuals are able to distinguish between behavior-environment interactions and personal feelings, they would be able to find the underlying reason for certain behaviors. If the students have the ability to determine the root cause of their sexual practices outside of their environmental influences, he/she may be able to manipulate the environment to support healthier and safer sexual practices (Brigham, 1989). Once a student is able to define this skill and incorporate it into practice, he/she will be more likely to practice safe sex because he/she personally wants to without any environmental influence.

As mentioned above, many components factor into unsafe and unhealthy sexual practices for the Batswanan college population. Many students have environmental and cultural factors that contribute to the potential barriers to practicing safe sex. The very basic factor is the lack of resources available to the students. There must be an increase in available resources to help the students make better decisions if they choose to be sexually active. Condoms must be available to the students and education on application must be widely incorporated.

Additionally, and perhaps most importantly, changing the communication skills among the young university students will assist with self-management. It is important to implement self-management skills in the way students communicate with one another,
particularly refusal skills for young women and reflective listening skills for men. A transformation in communication and self-management would help the students decrease negative environmental factors (i.e. alcohol use and participation in unsafe sex) and reinforce the positive results of healthy sexual decision-making practices.

Brigham (1989) provided suggestions on how to create a successful self-management program with a centralized philosophy. The instructions were simple: students learn by doing; instructors must facilitate learning by providing appropriate cues, guidance, and feedback; the experience should include active involvement from the students and the instructor; the instructor should provide immediate feedback as well as promote and guide students’ responses. Brigham’s four overall objectives of any self-management program are: “1) teach the basic concepts and procedures of behavior analysis so they are relevant to the students’ everyday life, 2) teach the basic concept of science as related to experimental methods and analysis of ideas, 3) give the student experience conducting psychological experiments and analyzing psychological concepts, and 4) give the student experience in successfully analyzing relevant self-management problems and conducting self-management projects” (pp. 75).

A complete 33 unit series was mapped out by Brigham in his book *Self-management for Adolescents: A Skills Training Program*. This is an instructor’s guide to managing everyday issues that may occur during a self-management course. Six particular units could be beneficial for instructors to keep in mind as they design a self-management program for the Batswana students. Table 2 lists the various units and examples of each.
Table 2. Instructor’s Guide to Managing Everyday Problems (Brigham, 1989)

<table>
<thead>
<tr>
<th>Unit</th>
<th>Concept of Unit</th>
<th>Objective of Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit 1</td>
<td>Measurement and Definition of Behavior</td>
<td>To teach students the importance of understanding issues and resolving conflicts (i.e. personal, cultural, and peer issues regarding sexual practices and how to overcome differences)</td>
</tr>
<tr>
<td>Unit 6</td>
<td>Operant (Voluntary) Behavior and Consequences</td>
<td>Help students understand the relationship between operant (voluntary) behavior and its consequences (i.e. voluntarily not wear a condom during sex, <em>will</em> increase your chances of contracting HIV/AIDS)</td>
</tr>
<tr>
<td>Unit 7</td>
<td>Reinforcement: Positive and Negative</td>
<td>Educate students on positive and negative reinforcement and how this influences behaviors (i.e. positive reinforcement from safe sex decreases chances of contracting HIV/AIDS thus affects their future; their country as a whole)</td>
</tr>
<tr>
<td>Unit 13</td>
<td>Stimulus Control: Generalization</td>
<td>Guide the student to understand how previous experiences influence social behavior (i.e. in the past, most students neglected safe sex practices due to reasons listed above, however, once they begin to implement self-management skills, they will be able to control external stimulus and environmental influences to make sound decisions independently)</td>
</tr>
<tr>
<td>Unit 15</td>
<td>Observation Learning: Modeling, Imitation, and Identification</td>
<td>This particular unit is very important for the Botswana student population, as much of their life and choices are heavily influenced by learning from others and imitating what their peers do. It is important for the students to understand how external factors, even if they are subtle, can affect their judgment and ability to be self-managers.</td>
</tr>
<tr>
<td>Unit 16</td>
<td>Starting a Fad: A Demonstration of the Power of Observational Learning</td>
<td>This unit is literally what it states. This objective gives students the power to start a new trend and change the existing structures of unsafe sex practices.</td>
</tr>
</tbody>
</table>

Significance to Nursing

Sex education and disease prevention in today’s society has become almost as common as stressing the importance of routine vitamin consumption. Schools, clinics, hospitals, and other health care organizations have devoted time and efforts to primary prevention. HIV/AIDS research continues to find ways to decrease the spread of the disease through education, prevention, and the push for safe sex. On a global level, this prevention and education process can appear to be more difficult to control and less
tangible. If a prevention program that is culturally relevant in the African community is put into practice by the “next generation” of young adults, it would change the face of HIV/AIDS forever. An active increase in HIV/AIDS awareness, safe sexual practices, and an entirely new way of thinking once the students acquire the self-management skills would have a great impact on global health.

Need for Further Research

A well formulated HIV/AIDS prevention program could be developed and implemented for the students at the University of Botswana. A successful program should include a combination of Kirby’s research on the best methods to decrease sexually risky behaviors and the implementation of Brigham’s self-management skills. Although most students are very aware of the problem with HIV/AIDS, many still believe the disease is not “our disease” (Brown et al., 2006). Many Africans continue to be unengaged and in denial of the disease, making any implementation of a program difficult. The general feelings and conceptions of HIV/AIDS in the African culture need further research. Any implementation of a prevention program would be useless if the researcher does not fully understand the way this disease is viewed within this population.

Brown and colleagues’ findings indicated the five major areas that were directly making students more susceptible to HIV/AIDS needs further research. Obtaining adequate resources such as finding appropriate instructors for the program, maintaining educational materials, and distributing a sufficient supply of condoms must be factored in before the start of any prevention program. Without adequate resources for an extended period of time, the success of the program would be compromised. Funding may be the deciding factor on obtaining and maintaining resources.
There are several other factors that require further research when implementing prevention programs, especially in the young adult age group. Issues centered on “stigmas, gender inequality, sexual coercion, cross-generational relationships and transactional sex” are all concepts people may be struggling with in their own sexuality (Halperin, Steiner, Cassell, Green, Hearst, Kirby, Gayle, and Cates, 2004, pp. 1913). These detailed findings regarding sexuality contribute greatly to potential behavioral changes that could be affected with a prevention program (Halperin et al., 2004).

Conclusion

Ideally, a prevention program can be developed that will be successful in reducing the number of new infection rates of HIV/AIDS at the University of Botswana. If successful, the program can be adapted for other areas in Africa. Currently, few programs exist, resulting in an alarming number of people living with HIV/AIDS. An appropriate program geared towards college-aged students in sub-Saharan Africa is simply unheard of at this time. A successful, manageable, and sustainable program could decrease student vulnerability and cultural barriers, provide adequate resources to assist in healthy sexual decision-making, increase and enforce positive communication skills, set guidelines for positive self-management, and increase positive sexual behaviors including safe sex practices.
References


