In-school HIV&AIDS counselling services in Botswana: An exploratory study

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Abstract

This exploratory study describes the provision of HIV&AIDS counselling services in Botswana junior secondary schools as perceived by teachers. A total of 45 teachers (age range = 20-55; teaching experience range = 0-21 years) from three schools participated. The participants completed a questionnaire on the types of HIV&AIDS-related counselling services provided in the junior secondary schools services, their self-rated HIV&AIDS counselling training needs and their perceived importance of the HIV&AIDS-related counselling services. Descriptive statistical analysis revealed a broad range of HIV&AIDS-related counselling services including life-skills education, care and support education and stigma reduction counselling. Teachers perceived a greater need for training in HIV&AIDS counselling skills and also in the use of information technology to support counselling.

Keywords: School counsellors; HIV&AIDS; Botswana; schools; teenagers

Introduction

It has been 23 years since the first HIV&AIDS case was diagnosed in Botswana in 1985. The HIV prevalence in the country of 1.7 million people remains among the highest in the world (UNICEF, 2006). For example, an estimated 37.4% HIV prevalence was reported in 2003 for pregnant women aged 15-49 years seeking antenatal care (National AIDS Coordinating Agency: NACA, 2002). Education continues to be the main strategy for controlling the spread of the disease (World Bank, 2001). A critical challenge to education is the need to prevent infection among the youth. Without effective prevention, care and support, education gains and investment will be severely undermined by the illness and death of young people during or shortly after their studies. Education encourages the adoption of lifestyles that prevent HIV infection.

Junior secondary school students (14-16 year olds) engaging in first sex are at high risk of HIV infection in the absence of counselling interventions (Gupta & Mahey, 2003; Malambo, 2002). Education and information are key to controlling HIV&AIDS spread among peer teens.

Role of in-school HIV&AIDS counselling services

Schools influence behaviour and inculcate values (Coombe & Kelly, 2002). Schools also offer ready-made infrastructure and easy access to teenagers from a variety of backgrounds. In-school counselling services provide students with the knowledge, values, and skills with which to make healthy decisions. For example, through their sexual health and HIV&AIDS education programmes, schools help students to develop life skills (Flay, 2002). These programmes may also prevent risky behaviour in teenagers. In-school counselling provides information on HIV&AIDS and its complications as well as how it can be prevented (De Young, 1992). In-school HIV&AIDS education makes students aware of the availability of preventive and care services and indicates how they can access the services to maintain health (Global Campaign for Education, 2004).

Guidance and counselling in Botswana schools

Significant progress has been achieved in institutionalising guidance and counselling in the Botswana education curriculum since the introduction of the Policy Guidelines on the Implementation of Guidance and Counselling by the Botswana government (Ministry of Education, 1996). For example, guidance and counselling services are being provided at more schools in the country (Moeletsi, 2005; Mokopakgosi, 2004). However, programme effectiveness and implementation audits have been infrequent (Government of Botswana, 1998, 2000, 2003; Muchado, 2002). The need and resources for in-school HIV&AIDS-related counselling could, if

understood and addressed, enhance responsiveness to the HIV&AIDS pandemic. Currently, school counsellors in Botswana are experiencing serious role and function overload due to their already heavy teaching loads (Moeletsi, 2005). Guidance and Counselling is a teaching subject in Botswana (Ministry of Education 1994), and all teachers are expected to incorporate guidance and counselling across the curriculum. Anecdotal evidence suggests that many teachers in Botswana schools do not have formal training in guidance and counselling.

Goals of the study

Most of the research on HIV&AIDS education in schools has focused on assessing changes in the target group (i.e. the children in the schools) in terms of knowledge, attitudes and intended or actual behaviour (Agha, 2002; Blinn-Pike, Berger, & Rea-Holloway, 2000; Pillai & Gupta, 2000). As noted in a recent report by ActionAid (2003), very limited research has been done on the implementation of HIV&AIDS counselling in-school, and most of what is known is based on anecdotal evidence (Kelly, 2000). The report identified and described (a) the nature of HIV&AIDS counselling services in a sample of Botswana junior secondary schools, (b) HIV&AIDS counsellor needs as perceived by school teachers, and (c) the perceived importance of HIV&AIDS counselling services and resources currently used.

Method

Participants and setting

The study was conducted in the three junior secondary schools in Gaborone West, Botswana. Gaborone West is a high HIV&AIDS prevalence zone. Forty-five of the 152 teachers from the three schools participated. Participating teachers were selected proportionally to school teacher enrollment. The three schools had a population of about 152 teachers. The study sample is indicated in Table 1.

Table 1: Study sample characteristics of teacher counsellors (n=45)

Demographics	Frequensies %
Gender of respondents	
Male	11(24)
Female	34(76)
Age group of respondents	
20-35	34(69)
36-55	14(31)
Professional qualification	
BA+PGDE/CE	17(38)
DSEGCE	28(68)
Position in school	
School counsellor/Teacher	8(34)
Class teacher	18(40)
HoD pastoral	19(42)
Number of years in teaching	
0-10	34(75)
11-20	11(24)
Professional counsellor	
Yes	40(89)
No	5(11)

Note: PGD/CE = Post Graduate Diploma in Education and Post Graduate Diploma in Counselling Education
DSE/GCE = Diploma in Secondary Education and Diploma in Secondary Education with Counselling Elective
HoD = Head of Department

Measuring instrument

Data were collected using a questionnaire designed by the first author of this study. The questionnaire comprised four sections. *Section A* consisted of demographic data covering age, gender and level of education. *Section B* had questions on what HIV&AIDS counselling services are available in junior secondary schools. For example, the respondents were asked if they had HIV&AIDS counselling services in their schools and the specific type of services provided. *Section C* had questions on how the respondents perceived their needs to provide HIV&AIDS-related counselling effectively in their schools. The respondents were asked, for instance, if they had received training, needed more training or needed more support from school administration.

The questions were pilot-tested with a sample of teachers (n=25) from schools similar to those that participated in the study. The schools for the pilot were not included in the main study. The goals for the pilot included (a) making sure the respondents understood the questions as intended; (b) enabling the respondents to suggest other questions that may be helpful; (c) determining reliability of the instrument; and (d) assessing the tool's clarity so that where there were ambiguities in the questions, amendments could be made accordingly.

Test-rest reliability of the instrument was .86 for the full instrument with a spacing period of three weeks in between administrations. Member checks were carried out with informant participants from pilot sample schools to check the credibility of the data.

Procedure and ethical considerations

Data were collected by the first author at the identified schools during normal school hours. The researcher sought permission to conduct the study from the Ministry of Education and the leadership of the participating schools. The respondents were informed that they were free to terminate the interview process at any time without any penalty. They were also made aware that there were no direct benefits for participating in the study.

Data analysis

Descriptive statistics were used for the major analyses, and T-tests were used to test for differences in the perceived impact of the HIV&AIDS-related programme resources.

Results

The study examined the nature of HIV&AIDS counselling services, perceived HIV&AIDS counselling needs of teachers and perceived importance of the services and resources. The results are presented below in terms of the research objectives.

Nature of HIV&AIDS counselling services

The top five specific types of counselling services mentioned by the school/teacher counsellors included developmental counselling (80%), life skills training (73%) and grief bereavement (47%). Other types less frequently mentioned included voluntary testing and counselling (22%) and family counselling (24%). Sexual and reproductive health counselling received less emphasis than other types of counselling.

Table 2: Counselling services provided in schools by teacher counsellors

Types of counselling services mentioning services (%)	Teacher/Counsellors	Rank
Individual	18(40)	4
Group	17(38)	5
Information	15(33)	6
Developmental (personal, academic, educational, vocational)	36(80)	1
Voluntary testing and counselling	10(22)	10
Grief bereavement	21(47)	3
Family	11(24)	9
Sexual/Reproductive	13(29)	7
Life skills training	33(73)	2

The respondents mentioned guidance and counselling committee members (53%) followed by regular class teachers (42%) and then school/teacher counsellors (39%) as mainly involved in providing in-school HIV counselling services (Table 3 below). School administrators also provided HIV&AIDS counselling services. Surprisingly, 22% of the respondents indicated that they did not know of any HIV&AIDS counselling providers in their schools.

Table 3: Participants in the provision of HIV&AIDS counselling services

Participants	Frequency and percentage (%)	Rank
Class teachers	19(42)	2
Guidance and counselling committee members	24(53)	1
Head of department pastoral	15(33)	4
Teacher counsellor	17(39)	3
Head teacher	13(29)	6
Deputy head teacher	13(29)	6
Do not know	10(22)	7

Perceived HIV&AIDS counselling needs by teachers

Table 4 shows the results of the analysis of perceived HIV&AIDS counselling training needs by the teachers. The respondents were asked to choose only one statement that best described their need. The list included: "I did not receive training at all"; "I need more training" and "I need more support from school administration" A significant majority (64%) of the respondents indicated that they had received no training in HIV&AIDS counselling. A significant minority (20%) of the respondents perceived a need for more training. About four percent reported a need for more support from the school administration.

Analyses were also carried out by type of counsellor, professional qualification and years of experience in teaching (Table 4). A smaller proportion of the school counsellors perceived training needs for themselves than did regular class teachers and administrators. Graduate teachers with a diploma in guidance and counselling also perceived a lower need for training than those with a diploma in secondary education. A higher proportion of teachers with less teaching experience perceived training needs for themselves than did those with more experience. Regular class teachers also expressed a higher need for education in national HIV&AIDS policies and stigma reduction counselling than other categories of teachers.

Table 4: Training and resource needs by teacher qualification and experience

	Type of counselor		Professional qualification			Teaching experience	
Needs	School/Teacher counsellor (n=8)	Class teacher (n=18)	HoD (n=19)	BA + PGDC/E (n=17)	DSEGC/E (n=28)	0-10 (n=34)	11-20 (n=11)
Trained teacher counsellors	3(37.5)	13(72.2)	5(26.3)	6(35.2)	8(28.6)	22(64.7)	5(45.4)
Policy guidelines	1(12.5)	6(33.3)	3(15.8)	3(17.6)	4(14.3)	10(29.4)	3(27.2)
Training in stigma and discrimination reduction	2(25)	4(22.2)	2(10.5)	2(11.8)	4(14.3)	7(20.6)	3(27.2)
Space	0(0)	1(5)	1(5)	0(0)	1(3.5)		1(9)

Note: The numbers in brackets are percentages. PGD/CE = Post Graduate Diploma in Education and Post Graduate Diploma in Counselling Education; DSE/GCE = Diploma in Secondary Education and Diploma in Secondary Education with Counselling Elective

Perceived importance of services and resources

Table 5 shows the mean importance ratings by teachers for a variety of services to support in-school HIV&AIDS counselling. HIV&AIDS awareness counselling had the highest importance rating (mean = 2.93) followed by care and support counselling (mean = 2.59) and behavioural change counselling (mean = 2.45). The services rated lowest in importance by teachers were networking (mean = 1.88) and monitoring and evaluation of HIV&AIDS programmes (mean =1.74).

Table 5: Perceived importance of services and resources

Services	Mean (range 1-5)	SD	Resources	Mean (range 1-5)	SD
Life skill programme	2.44	1.11	Teacher counsellors	3.44	1.55
Health and safety programme	2.43	2.41	Rooms for group counselling	2.00	2.52
Behavioural change modification	2.45	2.39	Rooms for individual counselling	1.84	2.38
Monitor. & eval. of HIV&AIDS	1.74	2.38	Counselling literature	2.47	2.34
Networking, e.g. NGOs	1.88	2.39	Computers	2.19	2.47
Care & support	2.59	2.51	Video projectors	1.77	2.38
Training in stigma & discrimination reduction	2.41	2.45	Overhead projectors	1.67	2.35
HIV&AIDS awareness	2.93	2.43	Stationery	1.91	2.45

Resources rated high in importance included trained teachers (mean = 3.44) and counselling literature (mean = 2.47). Teachers perceived training in HIV&AIDS counselling as significantly more important than the mere availability of counselling literature, $t_{88} = 2.232$ $p<.01$; effect size = .15. Teachers also considered their effectiveness to be significantly enhanced by training in the use of computers for counselling, $t_{88} = = 7.488$ $p<.01$; effect size = .23. Computers (mean = 2.19) and rooms or space for counselling were lower rated resources (mean = 2.00).

Discussion and conclusion

As could be expected, school counsellors and regular class teachers were the people most involved in presenting the guidance and counselling programme in junior secondary schools in

Botswana. Teachers with counsellor training perceived themselves better prepared to provide HIV&AIDS counselling than those with less or no training. The specific training that teachers with counselling qualifications received in HIV&AIDS would be of interest to related future studies.

Counselling services in Botswana junior secondary schools tended to emphasise a student developmental approach rather than HIV&AIDS counselling. However, a student development approach would also likely touch on HIV&AIDS counselling (Ministry of Education, 1996; Ministry of Health, 2004). Future research should investigate the extent to which HIV&AIDS counselling features in student development in Botswana junior secondary schools.

Several HIV&AIDS-related counselling programmes have been presented in Botswana schools including life-skills education, sexual and reproductive health education, voluntary testing and counselling, health and safety education, behavioral change, and care and support. These are key components of a comprehensive in-school HIV&AIDS prevention curriculum (Barth, 2004; Mpofu *et al.,* in press; Nation, *et al.,* 2003). However, the fact that providers of in-school HIV&AIDS counselling services perceived significant training needs in respect of themselves suggests that the identified programme components are probably not functioning optimally. Nonetheless, scope exists within the junior secondary schools guidance and counselling curriculum to enhance HIV&AIDS-related counselling using the existing curriculum structure rather than developing new programme components. Scaling up programme intervention on an existing framework has the advantage of easier implementation than would be the case with a new or significantly adapted curriculum.

Care and support counselling was rated important by Botswana teenagers some of whom are taking care of relatives who are infected or have full-blown AIDS in their homes. Furthermore, a significant minority of Botswana in-school teenagers most likely provide care to siblings orphaned by the HIV&AIDS pandemic. This care would extend to helping themselves and siblings avoid contracting HIV&AIDS. Care and support of relatives are culturally valued practices in Botswana native communities, and these pratices are easily transferred to taking care of relatives with HIV. Grief counselling was perceived as significantly represented services for junior secondary school students. We speculate that this need may be related to providing support to students who are losing or have lost relatives and peers to the pandemic. Future research should investigate the specific needs for which in-school grief counselling is provided.

Stigma reduction counselling was identified as an important area in which the paticipants needed retraining. Students with relatives living with HIV&AIDS and those who have lost relatives from the pandemic may be socially stigmatised or ostracised (Holzemer & Uys, 2004). Such counselling would help build psychosocial resilience in teenagers affected and infected by HIV&AIDS who may be social outcasts at school and in the community (Mabote, 1998).

Human resources (i.e. trained counsellors) were perceived as critical to the success of the in-school HIV&AIDS counselling programme in Botswana junior secondary schools, more so than information technology resources. A small effect size of .23 was observed for this factor suggesting a reliable preference in the teachers for training in HIV&AIDS counselling than for technology resources. Information technology resources are sparse in public schools in Botswana. Their lower importance rating can most likely be explained by unavailability and also by lack of familiarity on the part of the teachers in using those technologies.

Surprisingly, availability of space for counselling was perceived as a lower need despite the fact that most schools in Botswana are overenrolled, and teaching space is at a premium. The lack of prioritisation of counselling space needs could be the result of the existence of more basic needs in the provision of HIV&AIDS counselling services such as trained personnel.

Various limitations apply to the findings of this exploratory study. Firstly, it surveyed only a few schools in a suburban district of Gaborone. Counselling service needs of teachers and perceived importance may be different in schools in rural districts. Secondly, self-reports by

teachers rather than observational data were used. A non-standardised instrument was used for the study, and reliability in other settings or with a larger number of respondents is unknown. It is also virtually impossible to generalise from the study HIV&AIDS counsellor needs in other school settings in Botswana. Future research should examine teacher counsellor needs in a cross-section of schools by using a combination of self-report and observational data. In-school HIV&AIDS counselling in junior schools in Botswana holds great promise and could be enhanced by greater teacher preparation and the provision of facilities and other resource materials.

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