UNIVERSITY OF THE WESTERN CAPE.

KNOWLEDGE, ATTITUDES AND SEXUAL PRACTICES OF HIGH SCHOOL LEARNERS IN THE ERA OF HIV/AIDS IN A RURAL FREE STATE TOWN

A thesis submitted in partial fulfilment of the degree Master in Social Work by

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DATE: November 2008

ABSTRACT

The HIV/AIDS pandemic with its tremendous impact has been a major cause of death and disruption of people's lives. The youth of South Africa continues to be the most at risk and vulnerable by both being affected and infected by HIV/AIDS. There are non-conclusive research about the relationship between knowledge and behaviour of the youth in relation to HIV/AIDS. The goal of this research was to quantitatively explore the knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in a rural Free State town.

The objectives of the study were to:

- *Explore the knowledge levels, attitudes and sexual practices of high school learners at a selected rural town;*
- *Establish whether there is a difference in knowledge levels and sexual behaviour pattern of learners according to age at first sex;*
- *Establish whether there is an association between knowledge levels and sexual behaviours; and*
- *Explore problems experienced by participants when seeking information or help and what their suggestions are on prevention strategies.*

A total of 462 high school learners who were enrolled for grades 9, 10 and 11 in 2007 were selected to take part in the study. A self constructed questionnaire that also included open-ended questions for qualitative exploration was used to collect data. A total of 303 respondents responded. The SPSS programme was used for data analysis and open questions were analysed thematically. Measures were employed to ensure a form of face validity and reliability of the questionnaire. Results indicated poor knowledge levels of HIV/AIDS and positive attitudes towards people infected by HIV/AIDS. Teenagers' sexual practices are rife but the majority of sexually active respondents have reported the use of condoms at first sex and last occasion of sex. Based on reported negative experiences at clinics, parental homes and schools regarding sexual health promotion and knowledge sharing, robust engagement of community leaders and elders working

together with teenagers in programmes designed to enhance HIV/AIDS education is recommended.

KEY WORDS

Attitudes

HIV/AIDS

Knowledge

Sexual practices

DECLARATION

I declare that this study titled *"Knowledge, Attitudes and practices of high school learners in the era of HIV/AIDS in a rural Free State town"* is my own work and no plagiarism was done. The study was prepared for the fulfilment of the degree Master in Social Work at the University of Western Cape. I also declare that any work that is not mine but used and quoted is fully acknowledged as reference.

Name: Gladys Nkareng Klaas-Makolomakwe

Signature: _____

Date: _____

ACKNOWLEDGEMENTS

My greatest gratitude goes to God my saviour, for His love gave me strength, comfort and perseverance in my studies.

This research was made possible by funding received from the National Research Foundation (NRF) and much appreciation on this contribution. I also thank the Department of Education for opening doors and granting me permission to conduct this study in the two high schools of Phahameng, Bultfontein. I thank Ms Mmalekgetho Gaborone in particular, for her assistance led to prompt approval to conduct the study.

Exceptional thanks goes to Professor Susan Terblanche for giving me all the support and courage throughout this journey. Her devoted supervisory guidance always gave me hope that I can make it. South Africa needs people of her calibre.

All of my family who played a pivotal role in my success are a blessing and an honour in every aspect of my life. Tebogo and Boholo, your love and understanding kept me sane.

The following individuals are also acknowledged for their immeasurable assistance while conducting the study:
The Principal Mr Motatinyane, Ms Silo and her team.
The Principal Ms Nyamane, Mr Kelepu and Ms Matshanana (Administrative Officer).

Lastly, I would like to thank all the learners who participated in this study and their parents for granting permission for participation.

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CHAPTER 1: INTRODUCTION AND CONTEXTUAL INFORMATION

1.1 Introduction

The HIV/AIDS pandemic has been a major cause of death and disruption of people's lives. In numerous other ways it exerts a tremendous negative impact on the South African society in general. In 1999, the UNAIDS reported that approximately 50 million people were infected with HIV/AIDS internationally with over 16 million having died (Petersen, Bhagwanjee and Makhaba, 2001). According to Whiteside and Sunter (2000), the Sub-Saharan Africa is named the epicentre of HIV and AIDS as it holds approximately 70% of the global total number of people living with HIV/AIDS.

South Africa's rate of infection and transmission of HIV/AIDS has increased rapidly over years and evidence has shown SA having the fastest-growing AIDS and more HIV positive people (especially young people) than any other country (Skordis and Nattrass, 2002). Skordis and Nattrass (2002) cite two demographic models (ASSA2 and Metropolitan3) that predict the South African population growing with 10 million people fewer than what could have been in a no AIDS case-scenario.

One of the delaying factors of development in South Africa is its high levels of poverty and unemployment amongst others, which portrays South Africa's children as vulnerable and constantly in need of support (Streak, 2005). The problem of poverty also plays a major role in the situations where it overlaps mainly with the impact of HIV on affected households (Richter, Manegold and Pather, 2004). Whiteside and Sunter (2000) support this argument and point out that factors like environment, infrastructure, and social and economic status play an important role in a country's development and are clearly marked to increase the pandemic. This could suggest that HIV/AIDS has a bigger impact in South Africa, given its historical inequalities. This could make it easy for the pandemic to target the country and affect it in many ways.

Moreover, (Richter et al. 2004) mention that the legal and policy environment influence both the impact of HIV/AIDS on children, families and communities

as well as the extent of knowledge and acceptance of the pandemic as a problem that affects everyone. As it is, the environment not only changes the way people live but also challenges their tolerance of the pandemic hence knowledge contradicts with the idea of whether it is a disease meant for certain individuals or communities.

The South African antenatal survey estimated HIV prevalence in South Africa at 29,5% in 2004 as compared to 27.9% in 2003 (South Africa National Department of Health, 2006). The Free State province in South Africa rated among the top three or four provinces with high HIV prevalence and in 2004 the rate was shown to be similar to that of the country at 29.5% (South Africa National Department of Health, 2005). These figures are also upheld by the Free State Provincial Growth and Development Strategy [FSPGDS] (2005-2014) also arguing that HIV/AIDS related deaths could be playing a role in the decline of youth population figures as the Free State Province ranks amongst the highest in terms of HIV/AIDS prevalence in South Africa. Pelser (2006) indicates that the HIV prevalence rates for the total Free State population will most likely peak by 2007, and in the same year, the number of new AIDS cases may increase by more than 60%. It is further estimated by Pelser (2006) that the total number of HIV infections is to increase by more than 20% over the next few years.

Pelser (2006) furthermore indicates that Free State compared with the other eight provinces, has the following current and projected demographic characteristics:

- The slowest total population increase (3.7%) for the period 2001-2006;
- The only province projected to see an actual population decline over the period 2003-2010;
- The second highest HIV prevalence rate in the total population (17.7%) in 2003, and the highest (17.1%) in 2010;
- The third lowest life expectancy at birth in 2003 (49 years), and the second lowest in 2010 (40 years);
- The third highest under-five mortality rate (106 per 1 000) in 2002;

- The highest crude death rate in 2001 and 2011.

The youth of South Africa continues to be the most at risk and vulnerable by both being affected and infected by HIV/AIDS. Hartell (2005:3) suggests that South African youth "must be regarded as a high-risk group for HIV infection". UNICEF, UNAIDS and WHO (2002) in Hallman (2004) estimates showed South Africa's prevalence rate at 18,2% compared to 1,1% global prevalence among the 15-24 age groups. Research by Leclerc-Madlala (2002) reveals that in greater areas of Durban, young girls at the age of 13 are diagnosed as HIV positive. Shisana and Rehle et al. (2005) reiterate that "the largest increase in prevalence (16.9% in 2005 compared to 12% in 2002) was found among females aged 15-24". These estimates surely postulates alarming shock as this age group is supposedly the active generation of the country.

The survey conducted by Shisana and Rehle et al. (2005), raise concerns about the existing levels of knowledge among South African young people aged 12-14. In another study, Peltzer and Promtussananon (2005:4) found that knowledge of HIV/AIDS was generally not satisfactory among junior secondary school adolescents; poor in other areas, and satisfactory in yet some other areas. Knowledge is significantly higher in urban than in non-urban schools.

In contrast, other researchers seem to allude that the knowledge of the youth about the contraction and transmission of the pandemic is high but a change in engaging with sexual risky behaviours is weak. For instance, Maswanya, Moji, Horiguchi, Nagata, Aoyagi, Honda and Takemoto (1999) indicate that school going youth "failed to change their behaviours" even though they were aware of the risk. James, Reddy, Taylor and Jinabhai (2004) allude that even though youth knowledge levels are very high for the causes and spread of HIV/AIDS, there is behaviour deviation for issues relating to protection and seeking of treatment. The study of Pharaoh (2004) indicates that learners are knowledgeable about the transmission of HIV, but lack sufficient knowledge about prevention.

Attempts to minimise the risks of contracting HIV/AIDS among young people should be made possible and actively upgraded by robust research that focuses on seeking the views of young people. It was therefore imperative for this research to be undertaken to explore the knowledge and sexual practices of high school learners in the era of HIV/AIDS and further enquire about their challenges and suggestions towards prevention strategies.

1.2 Research problem statement and motivation for the study

There are non-conclusive research about the relationship between knowledge and sexual behaviour of the youth in relation to HIV/AIDS. Also, prevention and awareness strategies on HIV/AIDS seem not to have made much impact in bridging the gap between awareness and behaviour change among the youth (high school learners). Ongoing and comprehensive research seems necessary to explore their knowledge of HIV transmission and their sexual behaviour. The local data base of the National Research Foundation (NEXUS) indicates a dearth of research on this issue in rural areas. My interest and concern was to conduct research in a specific rural area of the Free State because there is a lack of social work resources that can assist in addressing social problems of this nature.

1.3 Goals of research and objectives

1.3.1 Goals

The goal of this research is two fold: namely to quantitatively explore the knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in a rural Free State town, and secondly to explore challenges experienced by learners when seeking information and their suggestions on intervention strategies.

1.3.2 Objectives

The objectives of the survey were to:

- To explore the HIV/AIDS knowledge levels, attitudes and sexual practices of high school learners at a selected rural town;

- To establish whether there is a difference in knowledge levels and sexual behaviour pattern of learners according to age at first sex;
- To establish whether there is an association between knowledge levels and sexual behaviours;
- To explore participants' perceptions about the information resources and what their suggestions are on prevention strategies.

1.4 Methodology

This section is aimed at orientating the reader on the research methodology and a detailed discussion on the methodology is presented in chapter 5.

A quantitative survey using self-constructed questionnaires was utilised to:

- Explore the knowledge levels, attitudes and sexual practices of high school learners at a selected rural town.
- Establish whether there is an association between knowledge levels and sexual behaviours.

Open-ended questions were included to qualitatively explore participants' experiences when seeking information and what their suggestions are on prevention strategies.

A total of 462 high school learners were invited to participate in the survey and a total response of 303 participants was obtained. The demographic details of learners included gender, school grade, age and language, some of which were used as independent variables in the study.

The self-constructed questionnaire entailed forty one questions on learners' knowledge of HIV/AIDS; attitudes towards people infected by HIV or suffer from AIDS; and sexual practices of learners. The questionnaire was based on guidelines of the World Health Organization (WHO, accessed 2006) for such surveys and the researcher also adapted questions from related studies such as Flisher, Ziervogen, Chalton, Leger and Robertson (1993). Data analysis was performed using SPSS to conduct frequencies, chi-square analysis and

cross-tabulations as the quantitative data obtained mostly allowed for ordinal and nominal levels of measurement in the analysis. Knowledge, attitudes and sexual practices were used as dependent variables. The qualitative data obtained was analysed thematically.

1.5 Ethical consideration

The researcher followed ethical guidelines as standards and basis of evaluating self conduct (see PIS addendum (i)). In this research, the following ethical guidelines were followed:

- Ethical clearance to conduct the study was obtained from the Senate Research Committee of the University of the Western Cape.
- Permission to conduct this study was granted by the Free State Department of Education and the management of the schools.
- Written consent from learners and parents/guardians were also sought.
- Participants information sheet (PIS) and consent form explaining ethical guidelines were retrieved from parents and learners who signed and indicated their willingness to participate in the study. (PIS of parents were translated into Sesotho; the dominantly used language). See addendum (ii).
- Participants were fully informed about the purpose of the study and anonymity when completing the questionnaire.
- Voluntary participation in which they were free to withdraw at any time during questionnaire data collection was communicated to participants.
- No private and personal information was asked and participants had a right to withhold any information they wish to.

1.6 The study limitations

A total sample of 462 learners was invited to participate in the study. Although 303 (64%) response was obtained, the results can only be generalised to the population of this study. The questionnaire contained questions that were of sensitive nature and the respondents might have experienced difficulties in responding. Participants did not respond to some questions. This could be due to participants not fully understanding some

questions or not being comfortable in responding. Although the questionnaire entailed open-ended questions, the initial intent was to use focus groups for qualitative exploration but this was declined by the Ethical Committee for fear of possible stigmatisation of participants. Therefore, no in-depth exploration and probing could be done and the open-ended questions in the questionnaire were the only way to gather qualitative information.

1.7 Clarification of main concepts

HIV/AIDS refers to Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (Whiteside and Sunter, 2000).

Knowledge is defined as facts, information and skills acquired by a person through experience or education and it's also the theoretical or practical understanding of a subject (Pearsall, 1998).

Attitudes are "a way of thinking or feeling about someone or something" and **Sexual practices/behaviour** refers to the way in which someone or something behaves (act in a certain way) and in this regard referring particularly to sexual behaviour (Compact Oxford Dictionary, 2001).

1.8 Lay-out of the Thesis

This section presents the layout of the thesis to the reader according to the chapters and annexure.

Chapter 1 focuses on the introduction and contextual information giving orientation to the methodology of the study. Ethical considerations, study limitations and main clarification of concepts are also part of this chapter.

Chapter 2 forms part of the literature and takes particular view on the sexual behaviour of the youth used for the purpose of this study. It also discusses factors such as culture and religion, gender inequality and access to information and media on how these factors influence the sexual behaviour of the respondents.

Chapter 3 focuses on presenting the theoretical perspectives on knowledge, attitudes and behaviour and also looks at theories/models of intervention with

regards to HIV/AIDS and sexual behaviour. **Chapter 4** is a brief discussion on existing school policies and programmes in South Africa.

Chapter 5 gives a description of the research design and methodology of the study and **chapter 6** entails the findings of the study.

Chapter 7 focuses on the discussion of findings and presents literature relevance. This chapter also provides the conclusions and recommendations of the study.

CHAPTER 2: YOUTH SEXUAL BEHAVIOUR

2.1 Introduction

Strydom and Strydom (2002) mention that "young people are constrained in their behaviours by social, economic, legislative and other factors that are beyond their personal control". Tefera, Challi and Yoseph (2004) reiterate that it is these different factors that directly or indirectly affect the magnitude of HIV/AIDS in a given society. This chapter aims to provide a synopsis of recent research findings on sexual behaviour of young people. It also looks at major influential factors such as culture and religion, gender, socio-economic status and access to information on the behaviour and decision making of young people regarding sexual choices.

2.2 Young people and sexual behaviour

According to Strydom and Strydom (2002), there is evidence to suggest that young people across the world are having sex earlier than in the past. This seems to suggest that young people get too much exposure to sexual activities which raise concerns especially in the midst of HIV/AIDS. Peltzer and Promtussananon (2005) voice concern about few studies of sexual behaviour when considering the high prevalence rates of sexual intercourse, infrequent use of condoms and other contraceptives, and significant proportions of adolescents who have two or more life time sexual partners. The authors cite South African studies in which sexually active learners indicated never having used condoms and of those, two related studies indicated that respondents complained of intimidation, resistance and poor receptions at the clinics when requesting condoms. However, in another study by Peltzer and Promtussananon (2005), they point out that high school students actually complained about condoms limiting their sexual pleasure and also that it lead to lack of trust in the partner, challenged male ego and that condoms were associated with sexually transmitted diseases.

In their results about sexual behaviour, Peltzer and Promtussananon (2005) found that among the sexually active group, the average age of first sexual intercourse was 16 years. The age percentages were significantly lower for

boys (14 years) than girls (15 years) and significantly lower among urban schools' students than those from rural schools. Both male and female students indicated having used condoms at first sex (64% and 79% respectively). The percentages for condom usage were seemingly lower (56%) at last sex and significantly higher for female than male students. This could suggest that subsequent engagements in sexual intercourse faced the likelihood of minimal use of condoms. Moreover a significant percentage of students indicated having had sex with someone much older (especially among females). Others indicated that they had sex for the exchange of gifts and others had sex with more than one partner (with males having more partners than females). This could suggest that young people find themselves being manipulated in various ways that compel them to stay sexually active whether with or against their will.

Several similar findings were observed in the survey on the sexual behaviour of young people between the ages of 15 to 24 conducted by Pettifor, Rees, Steffenson, Hlongwa-Madikizela, Mc Phail, Vermaak and Kleinschmidt (2004). Sixty seven percent of the young people who took part in the survey reported having had sexual intercourse and of those, 48% were between 15 to 19 years of age. Among the sexually experienced youth, abstinence in the last 12 months was not associated with the active choice of protecting themselves from HIV, but was due to lack of opportunity to have sex or not having a sexual partner. This suggested that if these two reasons for not having had sex were to be fulfilled, they would have continued having unprotected sex. Among the sexually experienced, 8% reported having had sex at the age of 14 or younger (with males more likely than females) and 6% having been forced to have sexual intercourse (10% females and 2% males). The respondents also indicated having had more than one partner and the number increased with the age for both males and females. Findings from these studies indicate that once initiated, the engagement in sexual activities take their toll and if something is not done to influence young people to change their practices, they may continue engaging in risky sexual behaviour.

In a study conducted by Mbananga (2004), female respondents believed that education on not having many sexual partners was a waste of time as relationships were temporary. These respondents particularly felt that the use of condoms needed to be encouraged because the problem was how sex is practiced and not about the number of sexual partners. Both male and female respondents blamed one another. Females said males were promiscuous and males said it was females who infected them with sexually transmitted infections (Mbananga, 2004).

The Free State Youth Survey reported findings similar to other studies in terms of sexual behaviour (www.yru.ac.za). It is important to note that the age category of these young people was inclusive of the population concerned in this study hence it is germane to report on the findings. There were significant differences between male and female sexual behaviours. Males were found to be more sexually active, more sexually active at an early age, and tended to have different sexual partners (www.yru.ac.za).

Results also indicated that 37% from the total black respondents had more than one sexual partner in the past 12 months, amongst which 12% reported having had 4 or more partners over the same period. These were in contrast with only 1.9% of white respondents indicating having had more than one sexual partner in the period similar. For these results, the survey acknowledged and cited the suggestion of Pelser (2006) that "value clarification workshops as opposed to educational programmes" could perhaps help people to identify why many people prefer many sexual partners as opposed to fewer or one partner.

Compared to the national figures, 4.9% of Free State youth had their first sexual experience before the age of 12 and 22.3% already had sex by the time they turned 16 (national trends being 3% and 20% respectively). One third of black youth (unmarried but having more than one sexual partner) engaged in unsafe sex (www.yru.ac.za). The survey also found that almost a hundred percent indicated that the HIV/AIDS virus is sexually transferable confirming that irrespective of population group, young people in the Free

State are generally well-informed regarding the role of unsafe sex in the spreading of the virus. Lastly, the survey found that pertaining attitudes towards HIV/AIDS, there seemed to be less prejudice and stigmatisation among black youth towards HIV/AIDS infected people than among white youth

To summarise this discussion, one could at this point conclude that recent research indicates that young people continue to engage in risky sexual behaviour regardless of having knowledge of the risks associated with the behaviour. Thus, it calls for strengthening of intervention and exploration of the specific pulling and pushing factors influencing their decisions.

2.3 Discussion on some factors known to influence sexual behaviour

2.3.1 Culture and religion

Culture and religion play a major influential role on sexuality and the impact of one against the other is acknowledged in Meekers and Ahmed (1997). Culture is referred to as an important element of the foundation in every society and is described as attitudes and behaviour that are characteristics of a particular group or organisation and also helps individuals to form their identity (Khan, 2006). Rio (2006) implies that culture is a double-edged sword that can either promote or discourage change and development. Pertaining sexual behaviour, cultural practices have had strong influences that maintain talking about sex or contraceptives as taboo and in many African countries, cultural expectations require men, but especially women, to marry early and thus encouraging early sexual initiation in young people (Rio, 2006).

Pertaining to religion, Meekers and Ahmed (1997) suggest that the role of Christianity made an impact on traditional customs and religion and is amongst other factors that challenge traditional norms regarding female sexual behaviour. It could be acknowledged that culture and religion have a strong effect on the individual development and attach some barriers that serve to control human behaviour as accepted or not. Meekers and Ahmed (1997) endeavoured to note that with regards to sexual behaviour, many young people are reared in the context of specific cultural and religious beliefs

that influence their sexual behaviour. The two could be said to play a major role in considering how the youth protect themselves against the HIV/AIDS disease.

Verkuyl (1998) indicates how these two aspects could influence the way the youth think of sex and HIV prevention methods. The use of culture taboos to regulate behaviours and the spreading of information that contradicts the educational facts about sex, will confuse the youth and influence their perceptions. For instance, it was clarified that the youth may be taught that masturbation is a bad thing and doing it may lead them to blindness instead of the fact that it is a healthy way of abstention from the risks of sexual infections. As Verkuyl (1998) states, this may be done as part of socialising them to an extent that when they grow to maturity, they realise the deceitfulness of these taboos and then believe no warnings about risky sexual behaviours. Further, Verkuyl (1998) states that religion on the one hand influence youth education about safe sex because people uses religion to justify themselves stating that condoms are useless where sex is performed under commitment and thus blocking attempts to introduce safe sex education among the youth.

Myths are also at a central point that favours preferred cultural practices. Ajuwon, Olaleye, Faromoju and Ladipo (2006) indicate that adolescents harbour misconceptions such as the belief that a slipped condom can cause stomach discomfort and infertility. When it comes to communicating the truth about sexuality and what should be the ideal sexual behaviour conduct, culture specific parental practices serves as a barrier and Khan (2006) purports that parents do not understand the risk of not providing information. Khan (2006) claims that there are controversies and fears surrounding the issue of adolescent sexuality which often create barriers against giving adequate and comprehensive information and services to young people. Many parents and community leaders are said to recognise the need for sexual education but usually opposing the provision of extensive and intensive education on sex or sexuality. They think that learning about sex may lead adolescents to promiscuity.

Religion on the other side (even though acknowledged to delay unintended childbearing and marriage and also contributing to avoidance of early sex before marriage) entails implications that may deepen and influence sexual behaviour (Rio, 2006). For instance a study by Ajuwon et al. (2006), indicate that strong religious laws in Nigeria allow marriage of girls who have not started their menstruation. The role played by religion could be well reiterated by Rio (2006) arguing that as adolescents are burdened with choices of right and wrong, good or bad and yes and no, their religious beliefs, religious history and religious knowledge still offer a basis for decision-making.

2.3.2 Gender inequality

Gender inequalities between men and women have played an influential role in the spread of HIV/AIDS. Many studies as cited in Hargreaves and Boler (2006) have indicated that underlying gender inequalities leave women in particular, vulnerable to HIV. Furthermore, Strydom and Strydom (2002) cite that gender inequalities have serious consequences for adolescent sexual health.

One of the gender inequalities is observed as the less power that females have as compared to males when it comes to making decisions based on sex. Hargreaves et al. (2006) indicate that male sexual partners much older than young women pose one serious risk factor for vulnerability to infection. Evidence cited by these authors is suggestive that inequalities between older men and younger women affect how often a woman has sex, the type and frequency of sex, and whether condoms are to be used (Hargreaves et al., 2006).

High prevalence of violence against women and the encouraging of multiple sexual partners in some countries increase the risk of HIV infection (Rio, 2006). This could reiterate that violence against women has put women at risk of contracting HIV infections. As Hargreaves et al. (2006) support, the underlying gender inequalities exacerbate women's vulnerability to infection as it serves as an environment in which sexual violence is tolerated by young women. The WHO (2003) acknowledges that some women are threatened or

physically violated when attempting to negotiate safer sex through the use of condoms.

South Africa is one country in which violence against women has gained momentum and one in four women are being abused by partners (Outwater, Abrahams and Campbell, 2005). Outwater et al. (2005) cites a study by Abrahams (2002) in which 42% and 16% of male participants respectively reported using physical violence and sexual violence against their intimate partners of ten years. Of particular interest is that rape and attempted rape crime in the Free State province, although having observed a slight decline pattern since the period of 1994, 1999 and 2000, ranks the second highest after stock theft crime for the province. Thus, it clearly portrays the vulnerability of women and children in the province as far as sexual crime is concerned (Free State Growth and Development Strategy, 2005-2014).

Hargreaves and Boler (2006) acknowledge that it still remains socially acceptable in many African settings for men to have many partners but the same is unacceptable for women. An example is given by Ajuwon et al. (2006) stating the belief in Nigeria that boys should learn sexual reproductive health through experimentation and that girls should only be educated about reproductive health. This could be indicative of a social belief that approves of male engagement in sex with multiple partners at an early stage.

2.3.3 Socio-economic status and access to information

Strydom and Strydom (2002) point out that in the most extreme circumstances young people living in stressful situations may, for example, engage in survival sex in order to meet their needs for shelter, food and adult protection. In such precarious circumstances young people are not well placed to make rational decisions on the basis of new information or to practice newly acquired skills (Strydom and Strydom, 2002:261). Hargreaves and Boler (2006) acknowledge the opposing debate that higher education attainment may put women in particular risk, but also argue that increased education has a positive impact on economic prospects for both male and female. The debate may suggest that when better socio-economic

circumstances are gained by young people, decision-making in terms of engaging in risky sexual behaviour is less entertained and thus serve as a protective matter. Further, Hargreaves and Boler (2006) allude that economic opportunities afforded by higher education may prevent women from entering into activities that carry a high risk of infection.

Access to media information and socio-economic status are cited to relate directly with sexual experience and age at initiation of sex (Hallman, 2004). The South African community is involved in many activities and initiatives (e.g., Lovelife, Soul City, Khomanani and others) aimed at raising awareness about HIV/AIDS in the country. Some of the programmes are easily accessible via the media and community initiatives. However, as Hallman (2004) indicates "poorer young people" have access to fewer media sources. This disrupts the process of equally exposing young people to as much information about HIV/AIDS as possible.

Hallman (2004) reiterates that in the presence of knowledge on how to protect oneself from infection, given their situation, economic and socially disadvantaged young people may not always use this information and thus further risk engaging in unsafe sexual behaviours. It could be suggested that partly based on South Africa's given situation of inequality and high poverty trends, accessibility and exposure to information still depends on socio-economic status and residential areas. This could mean that despite the fact that information is made available; youth in cities and affluent areas are more exposed to information flow than the youth in small towns, farms and villages that are not well resourced.

However other research has found differing results as far as access to media information and socio-economic status are concerned. In contrast to popular findings that suggest that the poor not only start sex earlier but are more sexually active than those from affluent homes, multivariate analysis in Isiugo-Abanihe and Oyediran (accessed in 2007) suggested otherwise. Their findings revealed that those who had access to media information and were from higher socioeconomic status homes were sexually more active than

those having low access to media information and were from less affluent homes.

2.3.4 Summary

This chapter presented various research findings as far as sexual behaviour of young people is concerned. Young people today have sex earlier in their life and males are more sexually active at an early age. The use of condom, especially at last sex is rare and various reasons are mentioned by young people as to why they are not using condoms. Abstinence is not part of wanting to protect oneself against HIV/AIDS amongst young people but is due to lack of opportunity to have sex or not having a sexual partner. Young people indicate that condom usage needs to be more actively encouraged as no one between the male and female sexes is willing to take the blame for infection. Major influential factors such as culture and religion, gender, socio-economic status and access to information play a major role in influencing behaviour and decision making with regards to sexual choices.

CHAPTER 3: THEORETICAL PERSPECTIVES ON KNOWLEDGE, ATTITUDES AND BEHAVIOUR AND INTERVENTION THEORIES/MODELS OF SEXUAL BEHAVIOUR AND HIV/AIDS

3.1 Introduction

Assessing sexual behaviour among the learner population affords deeper understanding of risk factors that youth engage in. It could further help in identifying early intervention strategies to prevent further spread of the illness as well as engagements in risky sexual behaviour.

The following chapter presents some existing debates and theoretical views about the relationship between knowledge, attitudes and behaviour. It explores the existing intervention/models of sexual behaviour and HIV/AIDS.

3.2 Views about the relationship between knowledge, attitudes and behaviour

Existing studies present various researchers having different notions about the influences knowledge has on behaviour change. Different factors have been explored to determine whether knowledge influences change in sexual behaviour.

Goodwin, Kozlova, Nizharadze and Polyakova (2004) contend that peer pressures plays a major role in influencing beliefs such as *"condoms are a threat to manhood"* and serve to weaken the relationship between any increase in knowledge and subsequent safer sexual practices. Swartz, Kagee, Kafaar, Smit, Bhana, Gray, Lesch, Lindegger, Milford, Richter, Seedat, Skhosana and Stein (2005) also note that peer pressure plays a crucial role in influencing behaviour change among adolescents, especially in relation to initial sexual engagements, attitudes towards HIV, condom use, and safer sex behaviour. These authors purport that knowledge does not influence behaviour but that environment and social context are the main drivers.

The findings of Ntozi and Kirunga (1997:176) allude that attitudes are significantly associated with the number of people known to be sick due to AIDS. Ntozi et al. (1997) regard the individual's attitude playing an important role in the prevention of a disease, especially when looking at the degree of susceptibility, seriousness of illness, benefits and barriers of taking action.

Smith (2003) on the other hand believes that fear and concern motivate behavioural change and leads individuals to worry about themselves. His study postulates that when levels of worry are regressed, a person worrying about contracting HIV/AIDS is little influenced by his own characteristics or behaviour, but greatly by the behaviour and worries of other people in his life. Sharing a slightly different yet similar belief, Harrison, Smit and Myer (2000:285) acknowledge that information; education and communication form a strong basis for HIV prevention. They argue that numerous studies have "*shown an impact on knowledge and attitudes, but fewer have demonstrated an influence in actual behaviour"*. They conclude that there is "currently a substantial gap between high levels of knowledge and low levels of preventative practice" (Harrison et al., 2000:286).

3.3 Intervention theories/models of sexual behaviour and HIV/AIDS

Smith (2003) categorizes models for examining sexual behaviours into individual and social models on risk behaviours and behavioural change. These models have been adapted and used in various programmes aimed at addressing HIV/AIDS (Denison, 1996). Smith (2003), cites the UNAIDS (1999) arguing that individual behaviour models are embedded in their social and cultural context. The proposed argument could suggest the recognition that both individual and social models should be implemented concurrently in order to observe the desired change in risky sexual behaviours. In support, Harrison et al. (2000) maintain that for interventions to be effective, the socio-cultural context of a community needs to be taken into account.

3.3.1 Individual Models

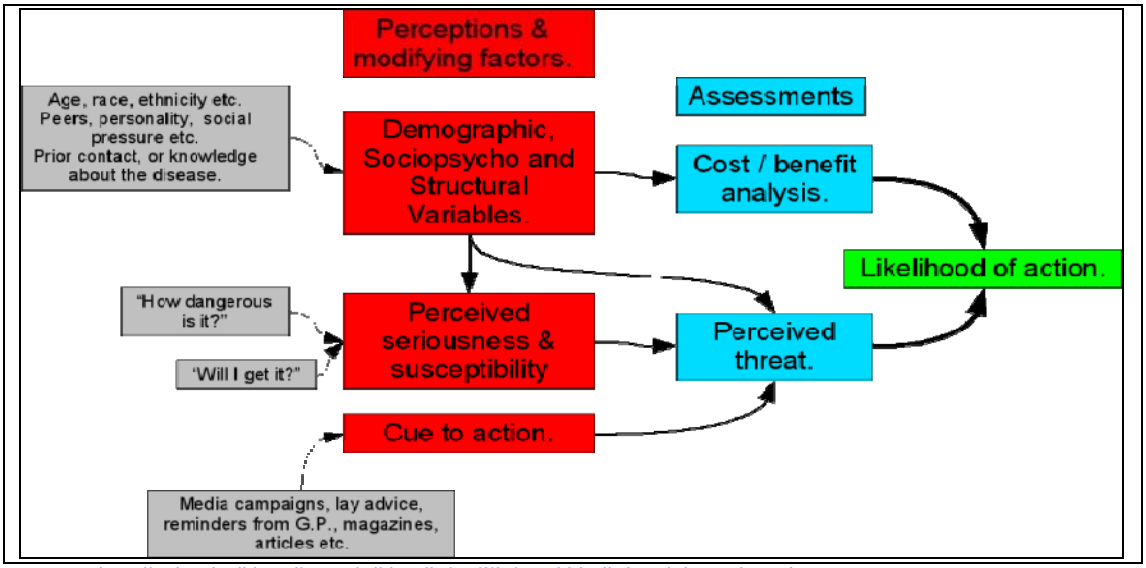
The individual models particularly hold an individual responsible for life choices and purport that perceived risks are a prerequisite for or correlate

behavioural change (Smith, 2003). The central point held for individual theories is that as psychological theories, they focus on an individual without assessing or addressing the potential impact of the external environment that is beyond the control of an individual (Denison, 1996). Thus, according to Denison (1996), the non-consideration of external factors (either environmental or economic) provides a limitation to individual models. A discussion on some major individual models used in the sexual behaviour and HIV/AIDS intervention is presented below.

3.3.1.1 Health Belief Model

This model was developed by Hochbaum, Rosenstock and Kegel of the US during the 1950s and contends that what a person believes concerning susceptibility to risk, leads to taking action towards change The model is defined as a psychological model basing its attempts on explaining and predicting health behaviour by focusing on the attitudes and beliefs of individuals and has been adapted for addressing the sexual risk behaviour and the transmission of HIV/AIDS (Denison, 1996). The fundamentals of the Health Belief Model (HBM) are based on three prominent factors purporting that people will engage in preventive behaviour if, they feel susceptible to a health condition; secondly if they believe that the condition can be severe (has negative outcomes) and lastly if they feel that there is more to benefit than what preventive behaviour may cost them (Peterson and DiClemente, 2000). According to Peterson and DiClemente (2000), the model has over the years gained reviews and below is a discussion of the key variables incorporating the amended versions (also see figure 1).

Figure 1: The Health Belief Model



Source: http://upload.wikimedia.org/wikipedia/en/f/f3/Healthbeliefmodel.png (2002).

3.3.1.1.1 Perceived threats

This variable involves the perceived susceptibility and perceived severity parts as both posing a joint function of perceived vulnerability, which determines the readiness to act and cited as "providing energy or force to act" (Peterson and DiClemente, 2000). In the perceived susceptibility part, an individual engages in subjective perception of the risks associated with contracting a health condition. The perceived severity part involves the individual's perception of both the physical and the social consequences of contracting a health condition or leaving it untreated. The physical consequences involve an evaluation of death or pain including medical and clinical consequences associated with contracting the health condition and the social consequences involve the effects on social relationships and family life (Denison, 1996).

3.3.1.1.2 Perceived benefits

The perceived benefit variable is based on the beliefs about the effectiveness of available options and strategies designed to reduce the threat of illness (Denison, (1996) and Peterson and DiClemente (2000)). Peterson and DiClemente (2000) suggest that individuals are unlikely to enact behavioural change options unless the perceived available strategies are viewed as likely to be effective and beneficial.

3.3.1.1.3 Perceived barriers

The variable of perceived barriers, also known as costs, engages the prospective negative elements of a health action (Peterson and DiClemente, 2000). An individual considers, amongst other things, the pain, expense and difficulties associated with taking a health action and will adapt, changing their behaviour only if the end result is worth more than facing these negativities. This means that the benefit of taking action has to be more favourable than the barriers associated with taking action (Peterson and DiClemente, 2000).

3.3.1.1.4 Cues to action

This variable of the HBM is assumed to be helpful in promoting action (Peterson and DiClemente, 2000) and motivates people to take action (Denison, 1996). Peterson and DiClemente (2000) state that the cues to action may erupt from internal (having symptoms of an illness) or external factors (knowing someone with the illness or gaining media exposure). For instance, an individual at risk of HIV infection may take action to change risky behaviour due to knowing people suffering from the illness; after watching a relevant programme on television; or because an already infected individual has fallen ill and presents known symptoms of the illness. Although the cues to action have not been extensively studied, researchers believe that demographic, sociological, psychological and structural variables may have indirect effects on preventative behaviour and therefore inhibiting initiatives to take action (Denison, 1996).

3.3.1.1.5 Self-efficacy

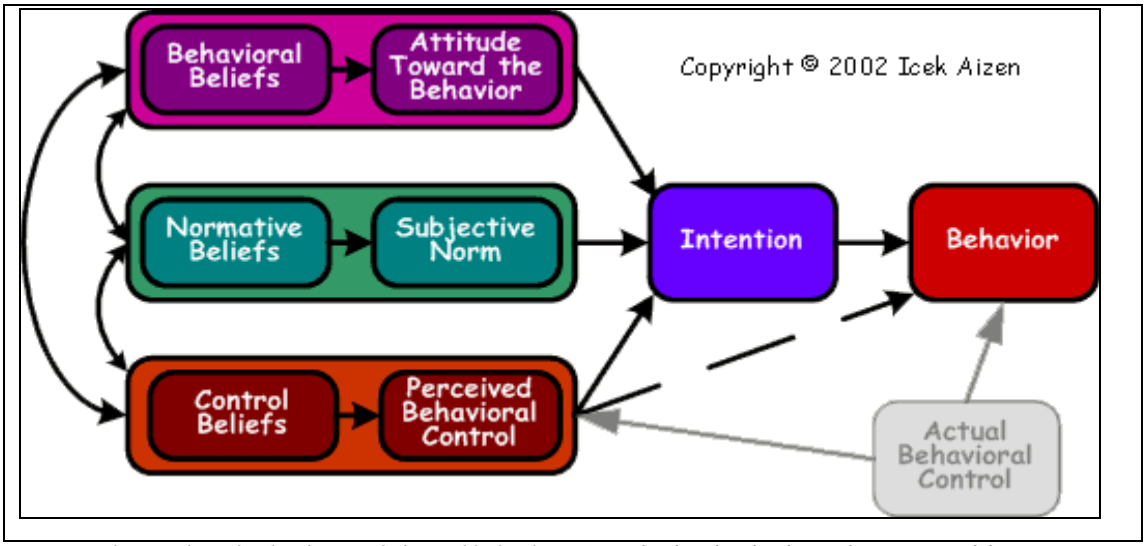
Self-efficacy is the aspect of the model that erupts from the individual's inner belief that he/she can successfully implement the required behaviour in order to achieve the desired outcome (Denison, 1996). Peterson and DiClemente (2000) allude that it is a personal belief of an individual that the preventative behaviour can be performed successfully and that he/she will experience positive outcomes.

3.3.1.2 Theory of Reasoned Action/Planned Behaviour

The Theory of Reasoned Action (TRA) was developed by Ajzen and Fishbein in 1975 and consequently the Theory of Planned Behaviour (TPB). These theories purport that once attitude has changed, intentions to reduce risk follows and one changes the actual behavioural pattern (Denison, 1996). TRA was changed to TPB after the realisation that behaviour is not 100% voluntary and that it can be deliberate and planned (UTWENTE, 2004). UTWENTE (2004) states that the basic assumption of the theory is that behaviour is determined by people's intentions, which are functions of their attitudes. In other words, people's intentions to act are based on their attitudes.

Peterson and DiClemente (2000: 29) state that the model has two factors that are in function to determine behavioural intentions necessary to perform a preventative action viz., the individual's attitude towards performing the preventative act and/or the individual's subjective norm of the preventative act. In particular, the intention is determined by attitude towards behaviour, subjective norms and perceived behaviour control. This means that when attitude and subjective norms are more favourable, perceived control is greater and the intentions to perform the behaviour become stronger (UTWENTE, 2004) (see figure 2).

Figure 2: Theory of planned behaviour



Source: Ajzen, I. (1991). The theory of planned behaviour. *Organizational Behavior and Human Decision Processes,* 50, p. 179-211.www.tcw.utwente.nl

3.3.1.3 Social Cognitive/Learning Theory

The Social Cognitive Theory "*explains how people acquire and maintain certain behavioural patterns, while also providing the basis for intervention strategies"* whilst the Social Learning Theory emphasizes the importance of observing and modelling the behaviours, attitudes, and emotional reactions of others Bandura (1977).

The theory purports that people need to be taught social and self-regulatory skills and the self-beliefs necessary to practice safer behaviours (Peterson and DiClemente, 2000). Furthermore, as Peterson and DiClemente (2000) state, it is also required of an individual to exhibit an inner belief (self-efficacy) in order to change behaviour. The authors cite Bandura (1977) that "without self-efficacy, people will not behave safely even if they know what comprises safer behaviour". Peterson and DiClemente (2000) present four components of the theory as discussed below.

3.3.1.3.1 Information

This component is necessary to highlight the types of behaviour that can cause one to contract HIV, to communicate what effective preventative behaviour entail and also need to contain information encouraging individuals to believe that they can effectively engage in prevention.

3.3.1.3.2 Development of social and self-regulatory skills

This component requires individuals to develop social and self-regulatory skills in order to change behaviour. The self-regulatory skills include knowing one's risk triggers, the ability to remind oneself how important safer behaviour is and reinforcing oneself for practicing it. The self-regulatory also determines effective ways of resisting social factors that may encourage risky behaviour.

3.3.1.3.3 Enhancement of social and self-regulatory skills

This component focuses on enhancing social and self-regulatory skills and requires exposure to role models and techniques of changing behaviour. Changed behaviour needs to be practised in a more difficult context that ranges from fearless to more intimidating and difficult environments where

constant and regular feedback is given to individuals in every situation. With practice, skills are enhanced and self-efficacy becomes stronger and therefore making people more apt to use new skills and maintain their use in adverse conditions.

3.3.1.3.4 Social support/peer support group

This component is based on an assumption that people have greater influence on others and therefore suggests the importance of establishing social support groups as pro-prevention sources of support that boost self-standards.

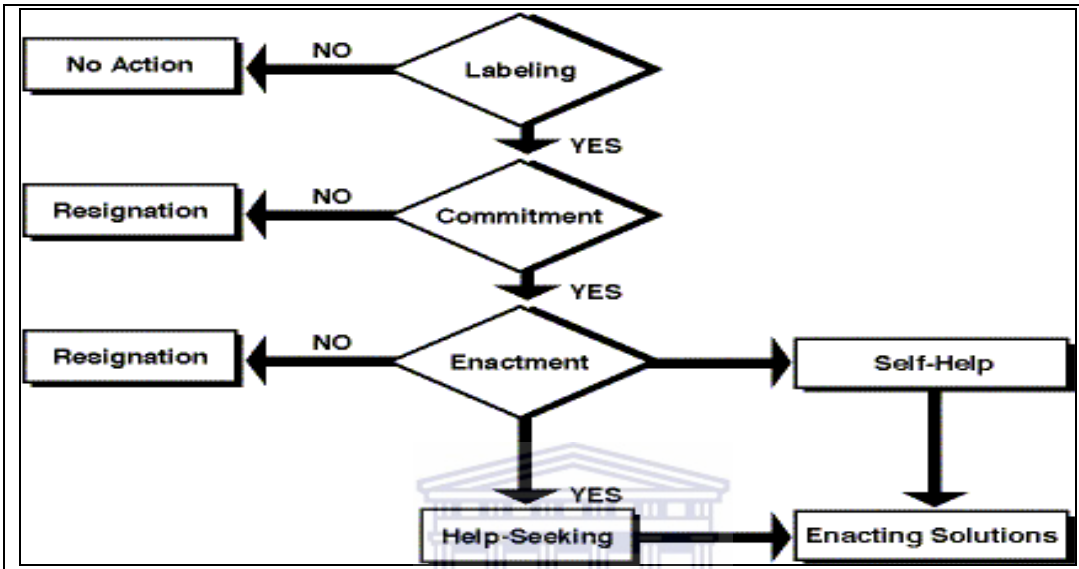
3.3.1.4 AIDS Risk Reduction Model

Introduced in the 1990s, this model is about an individual's self-description of being at risk and provides a framework for explaining and predicting the behaviour change efforts of an individual to change behaviour (Denison, 1996). It is a three stage model (see figure 3 below) that consists of the recognition and labelling of one's behaviour as a high risk, commitment to reducing that high risk (through engaging in low risk activities), and building on the commitment by seeking solutions as means of taking action to ascertain one's commitment (Shain, Piper, Newton, Perdue, Ramos, Champion and Guerra, 1999) (Denison, 1996). The ARRM also appends and integrates elements of other theories including HBM, Self-efficacy and decision-making theories (Shain et al., 1999). According to Shain et al. (1999), when used in HIV/AIDS related interventions, the model requires that individuals have knowledge of how HIV/AIDS is transmitted, recognises own personal susceptibility, and are aware that behavioural change comes with cost and benefits, self-efficacy and attainment of skills.

Although the ARRM acknowledges and may be influenced by both internal and external factors that motivate behaviour change in the three stages, its effectiveness is limited by its focus on the individual (Denison, 1996). This could imply that external barriers remain a challenge in the implementation of the model. For instance, one may consider an example where limited sexual negotiation may inhibit the progression of one partner who has engaged in

stages of this model due to not having control over the other partner's behaviour change. In fact, Denison (1996) recognises that individual movement across the stages may be negatively or positively experienced and therefore facilitates or hinders labelling of behaviour stage.

Figure 3: AIDS Risk Reduction Model



Source: Catania, J.A., Kegeles, S.M., and Coates T.J. (1990). Towards an understanding of risk behaviour: An AIDS risk reduction model (ARRM). Health Education Quarterly, 17(1), 53-72. In Family Health International (2002).

3.3.1.5 Stages of Change

The Stages of Change model was developed to assess out-patients smokers attending therapy and self changers in 1982 (Denison, 1996). The model maintains that whilst individuals with addictive behaviour engage in modifying their behaviour, they move through a series of stages (Prochaska, DiClemente and Norcross, 1992). It initially consisted of four stages and was considered to be linear; however, the fifth stage acknowledging that individuals go through a preparation period before implementing action was later incorporated. The incorporation of this stage, together with ten processes of change within this model, compelled for the rejection of the linear notion, hence the consideration that it is a cyclical model within which relapse often occurs through the stages (Denison, 1996) (Prochaska et al., 1992). The effectiveness of the ten processes of the model was measured in a study conducted by Prochaska, Velicer, DiClemente and Fava (1988) which was based on the assumption explaining that people change on their own and

in therapy and also supported that helping relationships are part of change in both therapy and natural environment. The five stages of the model as described in Prochaska et al. (1992) are presented below and figure 4 depicts the stages together with the ten processes of the model.

3.3.1.5.1 Pre-contemplation

This first stage of the model is characterised by the individual having no intention to change behaviour in the future. Many individuals in this stage either have no idea or some idea of their problem but this does not mean that they cannot see the solution. Often, those around them (i.e., friends, family or neighbours) are aware that these individuals have problems and it is often due to their pressure that they look for help. However, change in behaviour may only be demonstrated for as long as the pressure is there and once off, they relapse.

3.3.1.5.2 Contemplation

In the contemplation stage, individuals start to move into realising that a problem exists and seriously give thought to overcoming it. However, commitment to take action has not been made as they weigh both the pros and cons of overcoming the problem. It is in this stage that people can remain stuck for long periods.

3.3.1.5.3 Preparation for change

The stage of preparation combines the intention and behavioural criteria. Individuals in this stage are intending to take action in the next month and have taken action in the past year albeit unsuccessfully. Slowly and in small scales, change in behaviour is introduced. For instance, a classic example given is that of smokers changing their habit of smoking by reducing the usual number of cigarette smoked per day.

3.3.1.5.4 Action

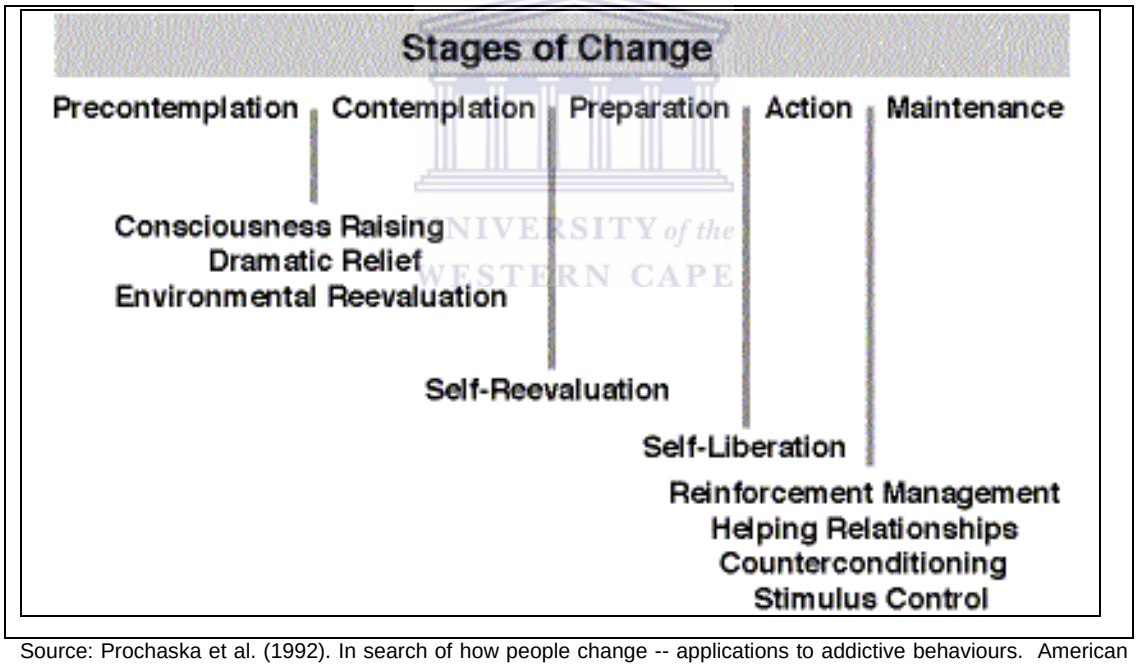
It is in this stage that individuals start implementing action through modifying behaviour, experiences or environmental factors that exacerbate the problem as means to overcome it. Ample time and energy is invested in action and

reaching a certain criteria e.g., abstinence, resembles successful change. Individuals having behaviour problems endorse certain empowering statements and self-fulfilling compliments for doing something to change.

3.3.1.5.5 Maintenance

The last stage of maintenance results when success in implementation of action has been reached and intense focus is on preventing relapse and consolidating achievements in taking action. There is no stagnation in this stage as it continues in the presence of change hence for some persons it lasts for a lifetime. The success of this stage of maintenance is considered based on a person's ability to remain free and engage in new alternative behaviour for more than 6 months.

Figure 4: Stages of Change model



Source: Prochaska et al. (1992). In search of how people change -- applications to addictive behaviours. American Psychologist, 47(9), 1102-1114. In Family Health International (2002).

The Stages of Change Model gained popularity in the field of HIV/AIDS and sexual behaviour research. For instance, Kelly, St Lawrence, Hood and Brasfield (1989) engaged the model based on the assumption that *behaviour change can curtail the spread of HIV/AIDS*. In this study, the authors purport that for slowing the spread of HIV/AIDS infections, it is important that persons at greater risk prompt change in risky behaviours and that they may need help

in changing behaviour especially when it is long standing and maintained by complex internal and external factors (Kelly et al., 1989). The model was also used by the Centres for Disease Control and Prevention (CDC) (1993) cited in Denison (1996) In an HIV/AIDS counselling and testing study.

3.3.2 Social Models

The models below argue that behaviour change is not determined solely by individual volition, but rather by social relationships, and also as well as structural and environmental factors which constrain people's options for change (Smith, 2003). Smith (2003) suggests that factors such as social pressures, peer influences, cultural expectations, and others restrict individual options but social models rather consider the flow of information. Below is a brief discussion on some types of social models.

3.3.2.1 Social Network/Inoculation Theory

The Social Network Theory claims that people are entangled in networks of relationships and are directly and indirectly linked to each other (Peterson and DiClemente, 2000). The Social Inoculation Models identify pressure as a contributing factor to engage in risk behaviours (Smith, 2003). The AIDS Conversational Network and Community Markers are evident and practical examples of Social Network Theory. AIDS Conversational Network was used in Malawi and attests that "opinions and actions of individuals are shaped by the opinions and actions of those around them" and the Community Markers, highlight membership in cultural groupings shaping responses to HIV/AIDS (e.g., region of residence assuming that people living in close proximity share similar cultural ideologies about the illness) (Smith, 2003).

Culture and religion can be said to be at the forefront of Social Network Theory as they are among the leading factors determining social networks (Peterson and DiClemente, 2000). Pertaining to culture for instance, Peterson and DiClemente, 2000, posit that because of pressures, societies are continuously forced to change some of their traditional practices in efforts to improve quality of life. Culture and religion as social phenomena, have been found to play a major role in considering how the youth protect

themselves against the disease (Verkuyl, 1998). Verkuyl (1998:10) states that “culture uses taboos to regulate behaviour” that contradicts the educational facts about sex and religion on the other hand influences youth education about safe sex because people uses it to justify themselves and thus blocking attempts to introduce safe sex education among the youth. Pertaining to the Inoculation Theory, the pressure experienced due to economic hardship may force youth to engage in risky behaviours like premature sex (Smith, 2003).

3.3.2.2 Gender and Power Theories

Gender and power theories relate sexual behaviour to inequality in relationships between males and females (Smith, 2003). Rivers and Aggelton (undated, www.undp.org) positioned that young women in many parts of the developing world have little control over how, when and where sex takes place and silence and ignorance among females are seen as signs of purity and innocence. Smith (2003) supports that the position of inferiority occupied by women as opposed to men in society is a factor blamed for the spread of HIV/AIDS in Sub-Saharan Africa. Citing Watts et al. (1998), Smith (2003) recognises a multitude of factors (e.g., financial dependence of women due to limited economic opportunity) forcing women to submit to partners demanding sex and thus exposing their vulnerability and inability to protect themselves against HIV infections.

3.3.2.3 Diffusion of Innovation Theory

The Theory of Diffusion is a unique theory that deals with new ideas and is necessary for an individual learning about a new idea. The diffusion process is particularly the process through which a new idea spreads via certain communication channels in the community (Peterson and DiClemente, 2000). The model constitutes five attributes of innovation namely:

- Relative advantage, which is the degree to which the new idea is perceived as superior to the idea it replaces;

- Compatibility, the degree to which the new idea is perceived to be consistent with existing values, experiences and needs of potential adopters;
- Complexity, defined as the degree to which an innovation is perceived as difficult to understand;
- Trialability, the degree to which an innovation may be experimented with on a limited basis, and
- Observability, the degree to which results of an innovation are visible to others.

Peterson and DiClemente (2000) indicate that the model was used in early decades of the AIDS epidemic to design HIV prevention programmes and social systems in HIV prevention (interrelated units) and as well as to make use of them to jointly achieve a common goal.

3.3.3 Summary

Research on the relationship between knowledge, attitudes and behaviour indicates varying perceptions about the influences knowledge has on behaviour change. Peer pressure, knowledge of infected people, attitudes and individual fears and concerns about contracting the disease and socio-cultural environment are amongst the leading factors that needs to be taken into account in the debate. The chapter takes a view at individual and social models/interventions used to address the HIV/AIDS pandemic. The essence in the individual models is that an individual is responsible for choices made in life and social models argue that social, structural and environmental factors plays a major role in individual behaviour change.

CHAPTER 4: A DISCUSSION ON SCHOOL POLICY AND PROGRAMMES

4.1 Introduction

South Africa, like many countries in the world is involved in the fight against HIV/AIDS hence policies and programmes were and are still being developed to address the challenges of the pandemic. WHO (2002) acknowledges South Africa as a country among others, that introduced HIV/AIDS education in its school curriculum. This chapter focuses on the education policy and the effectiveness of programmes addressing HIV/AIDS in schools and endeavours to summarise the policies and programmes in the country that are developed to address HIV/AIDS in South African schools.

4.2 Education policy and effectiveness of programmes addressing HIV/AIDS in schools

Schools and educators have been shown by research as the most trusted source for young people to learn about HIV (Hargreaves et al., 2006). A study conducted by Jaiswal, Magar, Thakali, Pradhan and Gurubacharya (2005) found that "the school education programme was successful in spreading statistically significant knowledge of HIV and curability of STI". In another study conducted by Hingson, Strunin and Berlin (1990), findings indicated that the proportion of teenagers who had discussed AIDS in schools increased by 30% due to the introduction programmes aimed at addressing HIV/AIDS in schools. The study also found that the proportion of sexually active teenagers who reported changes in sexual behaviour to avoid AIDS increased by 18% and the proportion of adopted condom use to avoid AIDS increased by 17%. However, a significant increase in reported sexual intercourse in the past year (6%) was observed (Hingson et al. 1990). This could suggest that although media and school education may increase knowledge and stimulate some teenagers to change behaviour, for others, more personal forms of counselling may be needed.

DiClemente, Boyer and Mills (1987) suggest that school-based AIDS risk-reduction programmes, based on the most recent medical information about AIDS and HIV infection, and are effective means for combating the pandemic

in schools. In this study, the School Health programme is indicated to have demonstrated that adolescents' participation in Health Education curricula results in significant changes in knowledge, attitude and self-reported risk-behaviours (DiClemente et al., 1987). The authors suggest that the programme content should include information about the cause, acquisition, treatment and prevention of AIDS. Moreover, it is also suggested in this study that (i) age appropriateness of information; (ii) cultural relevance and sensitivity of the information; (iii) appropriateness of language and the style of communication; (iv) presenting AIDS information in the contextual framework emphasizing STDs (v) and ongoing evaluation, both short and long-term, should be addressed as educational components as a means of assessing programme effectiveness (DiClemente et al., 1987).

4.3 Discussion on Selected Programmes and Policies

4.3.1 HIV/AIDS Strategic Plan for South Africa 2000-2005

The strategy posits and acknowledges that the youth [15-35 years old] are the current and future economic powerhouse of the country. The main priority areas, together with the goals within each in this strategy, are:

4.3.1.1 Prevention

Goals within prevention priority:

- Promote safe and healthy sexual behaviour
- Improve management and control of STI's
- Reduce Mother to Child Transmission (MTCT)
- Address issues related to blood transfusion and HIV
- Provide appropriate post-exposure services
- Improve access to Voluntary HIV Testing and Counselling (VCT)

4.3.1.2 Treatment, Care and Support

Goals within treatment, care and support priority:

- Provide treatment, care and support services in health-care facilities
- Provide adequate treatment, care and support in communities

- Develop and expand the provision of care and support to children and orphans

4.3.1.3 Research, Monitoring and Surveillance

Goals within research, monitoring and surveillance priority:

- Ensure AIDS vaccine development
- Investigate treatment and care options
- Conduct policy research
- Conduct regular surveillance

4.3.1.4 Human Rights.

Goals within the human rights priority:

- Create an appropriate social environment
- Develop an appropriate legal and policy environment

The promotion of improved health seeking behaviour and adoption of safe sex practices and improving access and use of male and female condoms, especially among 15-25 years, are among the objectives of this strategy.

4.3.2 City of Johannesburg HIV/AIDS Programme

The programme builds on the existing HIV/AIDS Strategic Plan for Youth (2000-2005) and other provincial HIV/AIDS policies. The key components of the programme are:

4.3.2.1 Intersectoral Collaboration

Promoting partnership amongst all sectors of the public and involving the community to fight HIV/AIDS.

4.3.2.2 Community Mobilisation

Promoting non-discrimination and non-stigmatisation within the province aimed towards open and voluntary disclosure of HIV status within a supportive environment. Mobilising the community volunteering on TB treatment support, community and media AIDS campaigns. Activities such as

life skills education, peer education programmes and workplace programmes are also promoted.

4.3.2.3 Care Services Provided to Support Behaviour Change

HIV counselling and testing services, syndromic management of STI's in all health facilities, TB treatment , intensive treatment of STI's among commercial sex workers and provision of free condoms are promoted within this component.

4.3.3 National Policy on HIV/AIDS for Learners and Educators in Public Schools and Educators in Further Education and Training Institutions

In its commitment towards minimising the social, economic and developmental consequences of HIV/AIDS to the education system, all learners, students and educators, the Ministry of Education developed the policy on HIV/AIDS. The policy seeks to contribute towards promoting effective prevention and care within the context of the public education system.

The policy promotes and makes the following legal provisions in terms of HIV/AIDS management in schools and further education and training institutions:

- non-discrimination and equality with regards to learners, students and educators with HIV/AIDS;
- HIV testing and the admission of learners to a school and students to an institution, or the appointment of educators;
- Attendance at schools and institutions by learners or students with HIV/AIDS;
- Disclosure of HIV/AIDS related information and confidentiality;
- A safe school and institution environment;
- Prevention of HIV transmission during play and sport;
- Education on HIV/AIDS;

- Duties and responsibilities of learners, students, educators and parents;
- Refusal to study with or teach a learner or student with HIV/AIDS, or to work with or be taught by an educator with HIV/AIDS;
- School and institutional implementation plans;
- Health advisory committee.

4.4 Framework for Prevention Programme

Strydom and Strydom (2002) formulate and suggest a framework in Table 1 below to be used in prevention programmes. This programme is said to have been developed by student participants and encourages active involvement of aspects relative to youths such as games, ice-breakers, creativity, and interesting topics among others (Strydom and Strydom, 2002).

Table 1: Framework for prevention programme (Strydom and Strydom, 2002)

Physical Self	Emotional and Psychological Self	Social Self
Human sexuality: - Sexual response cycle - Sexual diseases - Contraception - Pregnancy	Further development of: - Self-assertion - Self-esteem Handling of emotions: - depression - suicide Responsible decisions	Relationships with: - family - peer group - opposite sex Communication skills Stabilising one's own identity: - gender roles - stereotypes
Healthy lifestyle: - Smoking - Alcohol and drugs - Unsafe sex - Abnormal behaviour e.g. bulimia	Sexual deviations: - Rape - Abuse - Homo-sexuality	

4.5 Summary

This chapter provides a brief outline of existing policy and suggested programmes in South Africa aimed at fighting HIV/AIDS in the public education environment. The policies make provisions for how the illness should be managed so that the human rights of those infected and affected may not be infringed.

CHAPTER 5: RESEARCH DESIGN AND METHODOLOGY

5.1 Introduction

This chapter entails the methodological approach used in this study. It reflects on the design and methodology which encompass the research tool (quantitative questionnaire entailing open questions) and the process of data collection. Finally, the chapter also looks at data analysis (performance of statistical and thematic analysis) used to explore the knowledge, attitudes and sexual practices of high school learners.

5.2 Goals and Objectives

The goal of this research is two fold: namely to quantitatively explore the knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in a rural Free State town, and secondly to explore challenges experienced by learners when seeking information and their suggestions on intervention strategies.

The objectives of the survey were to:

- To explore the HIV/AIDS knowledge levels, attitudes and sexual practices of high school learners at a selected rural town;
- To establish whether there is a difference in knowledge levels and sexual behaviour pattern of learners according to age at first sex;
- To establish whether there is an association between knowledge levels and sexual behaviours;
- To explore participants' perceptions about the information resources and what their suggestions are on prevention strategies.

5.3 Research Approach and Research Design

The study predominantly used a quantitative approach to collect data. The researcher's first intention was to combine the quantitative-qualitative approaches by using focus groups for qualitative data-collection. This method for data-collection was not approved for fear of stigmatisation. In order to operationalise the qualitative objectives open questions were added at the

end of the questionnaire. The researcher thus still regards this as a form of combined quantitative-qualitative approach. According to Creswell (1998), the use of combined approaches (referred to as mixed methods) in research affords an opportunity of collecting diverse types of data that best provides an understanding of the research problem. De Vos in De Vos, Strydom, Fouché, Poggenpoel, and Schurink (1998:360) highlight the three models (two-phase, dominant-less dominant and mixed methodology design) identified by Creswell (1998) as useful when combining research approaches. The dominant-less dominant model in which the researcher utilises one single dominant paradigm (qualitative or quantitative) and uses the other to draw small conclusions of the study, was adapted in this study. The quantitative approach was used as the dominant paradigm (using a questionnaire as data collection) and the qualitative approach was used as the less dominant paradigm (qualitative data collected through open-ended questions incorporated in the questionnaire). Although the researcher acknowledged the limitations of the open-ended questions (see 1.7) data obtained from the open-ended questions provided rich information for thematic analysis.

Fouché and De Vos in De Vos et al. (1998:123) define a research design as "*a blue print or detailed plan for how research study is to be conducted".* Leedy and Ormrod (2001) also elaborate on the description of the research design as a complete strategy of attack on the central research problem and provide the overall structure for the procedures that the researcher follows, the data the researcher collects, and the analysis the researcher conducts.

A cross-sectional design was used in the study. The design affords an opportunity to collect data at one point in time (Creswell, 2003). In this design, the research population was identified, respondents were randomly selected and information was collected through a questionnaire.

This study had no control group and its focus was on comparing the dependent variables such as knowledge, attitudes and behaviour with independent variables such as age, gender and school grade.

5.4 Hypotheses

Knowledge and sexual behaviour

H0 = There is no association between knowledge levels of learners and their sexual behaviours in terms of ever having sex and continuing to have sex

H1 = There is an association between knowledge levels of learners and their sexual behaviours in terms of ever having sex and continuing to have sex

Knowledge and sexual behaviour

H0 = there is no association between knowledge and age at first sex

H1 = there is an association between knowledge and age at first sex

Attitudes and sexual behaviour

H0 = There is no association between perceived risk of infection and number of partners

H1 = There is an association between perceived risk of infection and number of partners

Attitudes and sexual behaviour

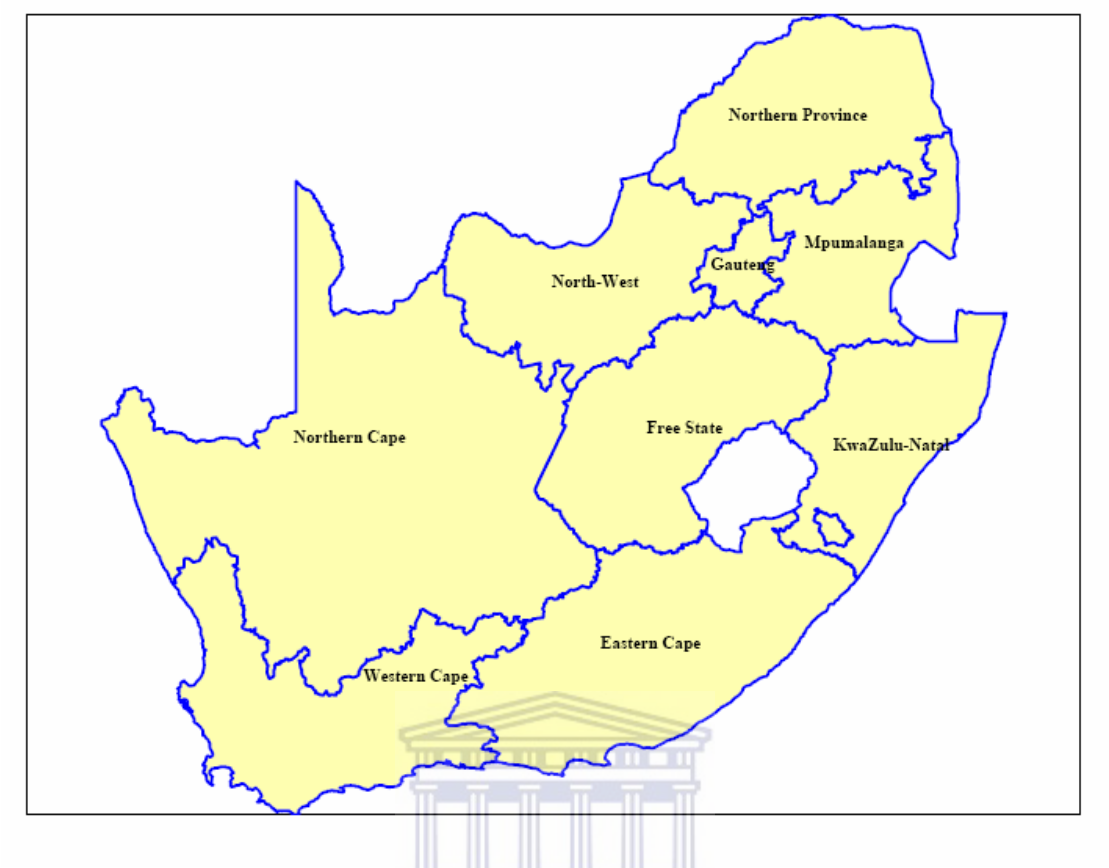
H0 = There is no association between perceived risk of infection and frequency of sex

H1 = There is an association between perceived risk of infection and frequency of sex

5.5 Research Setting and Population

The research was conducted in the Phahameng area of Bultfontein in the Free State Province (see figure 5). This area is characterised by low rates of employment and means of labour are minimal. Many people go out to work on the nearest farms, some work as domestic workers and few go out to work in the Goldfields mines of Welkom. The area falls under the Lejweleputswa District, which is an important agricultural area for the province and largely known for the Free State Goldfields (Free State Growth and Development Strategy, 2005) (see figure 6) and forms part of the Tswelopele District Municipality.

Figure 5: A map of South African Provinces



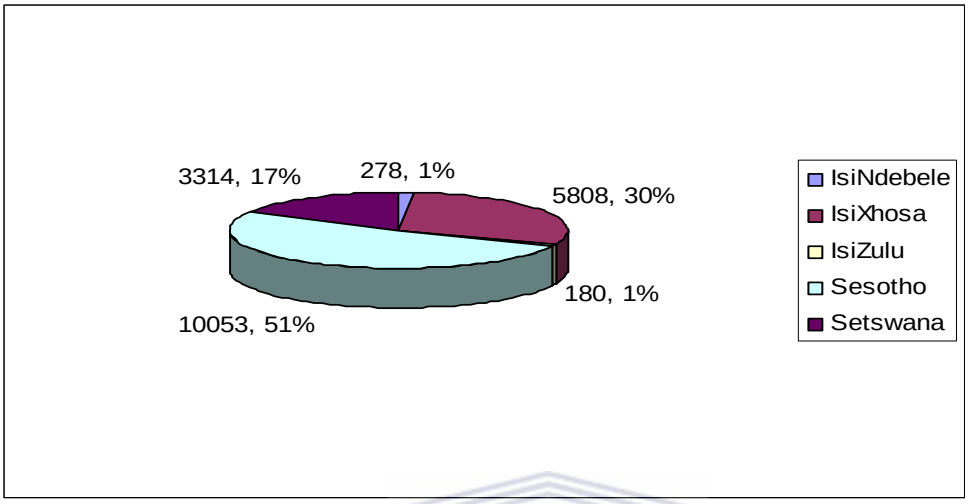
Source: HIV/AIDS Strategic Plan for South Africa 2000-2005. South Africa: February 2000.

Figure 6: A closer view of Bultfontein in the Free State province

http://www.africandestiny.com/map_freestate1a.asp accessed 03/09/2008

The dominantly used language in the Phahameng community is Sesotho (51.2%), followed by IsiXhosa (29.6%), Setswana (16.9%), isiNdebele (1.4%) and IsiZulu (0.9%) (Statistic South Africa Census, 2001).

Figure 7: Phahameng Language Statistics



Created on 31 March 2008. Source: SuperCROSS Copyright @ 1993-2008. Statistic South Africa

The research was conducted on the participating schools' premises during the hours recommended by the schools. These are the two community high schools in the Phahameng area.

The population of this study was high school learners enrolled for grades 9, 10 and 11 in 2007 without age exceptions. The reason for choosing this population in particular was solely because the grade 8 learners were just new and were adjusting to high school environment and the grade 12s were strongly focusing on their grade 12 final year (recommendations from schools). It was thus envisaged that the grade 9, 10 and 11 learners would provide valuable and rich data for the study. Population definition and setting are applicable to both the qualitative and quantitative research methodology.

5.6 Sampling

A total of 1540 learners from the two high schools were enrolled for grades 9 to 11, that is, 830 and 710 learners for Repholositswe and Rainbow high schools respectively. Systematic random sampling was employed to randomly sample learners from a non-alphabetically arranged list. Of the total

number of 1540 learners, thirty percent (462) of learners were selected using a third learner interval i.e. 249 from Repholositswe and 213 from Rainbow high schools and requested to participate in the study. A total sample of 303 learners from both schools participated in the study.

5.7 Data Collection

A self-constructed English version questionnaire (see addendum iii) was used to collect data over a week period. Two days were spent at each research site to administer the questionnaire to a group of participants. A venue was organised for respondents to complete the questionnaire at a central point. Respondents were asked to complete the questionnaire sitting separately and return it to the research assistants who did quality assurance of questionnaires at the spot.

5.8 Validity

De Vos and Fouché in De Vos et al. (1998:84) defines validity as referring "*broadly to the degree to which an instrument is doing what it is intended to do*". Content validity is crucial in this study as it is concerned with whether the instrument measures the concepts (in this case knowledge and attitudes) within the study. This process is judgemental and is applicable where various meanings of the concept are covered for the study purpose (Hudson, 1981 in De Vos et al., 1998).

The World Health Organisation (WHO) comprises examples of KAP (Knowledge, Attitude and Practices) questions suggested to be relevant when engaging in youth research (www.who.org, accessed 2006). The researcher constructed a questionnaire following the WHO guidelines as tool for data collection and consulted and adapted questions used by other researchers like Flisher, Ziervogen, Chalton, Leger and Robertson (1993). These questions were checked and validated against being youth friendly and understandable. The researcher also obtained input from the supervisor and research specialists to check for content validity. A pilot study was undertaken using draft questionnaires and the questions were further refined to ensure clarity and that they are easy to understand.

For qualitative purposes, the researcher made provision for the open-ended questions in the last part of the questionnaire that explored the views and granted opportunity for the learners to give suggestions on perceived roles that can be played by various people within the prevention of sexual risky behaviours.

5.9 Reliability

De Vos et al. (1998:162-163) refer to the reliability of an instrument as being when it is stable and consistent in what it measures. Although reliability of the instrument cannot be tested in this study, the researcher attempted to follow the following procedures as suggested in De Vos et al. (1998:163) to increase the reliability of the instrument.

- *Clearly conceptualising all constructs*

The researcher gave a theoretical meaning of all the major concepts to be used in the study.

- *Use multiple indicators of a variable/s*

More questions in a questionnaire are asked to measure aspects of variables in the study.

- *Use pre-test, pilot studies, and replications*

A draft questionnaire was used in a pilot study to test it before applying the final version to the prospective respondents.

5.10 The Layout of the Questionnaire

A questionnaire divided into five main sections was developed and entailed an assessment of the respondents' identity by demographic details (independent variables) such as age, gender, school grade and language (see addendum iii). The dependent variables included knowledge, attitudes and sexual behaviour of respondents in relation to HIV/AIDS. The questionnaire was based on WHO KAP surveys' guidelines (www.who.org, accessed 2006) and also adapted questions from related studies such as Flisher et al. (1993). The questionnaire entailed forty one questions in total.

The first section asked questions related to ***knowledge about HIV/AIDS,*** followed by the second section that enquired about **attitudes *about HIV/AIDS*** and the third section that was based on ***sexual behaviour***. These three sections had mainly closed-ended questions and a few indicative (in which respondents were asked to mention any other responses not mentioned in the questionnaire) questions. The fourth section was based on ***social factors*** and entailed both closed-ended and open-ended questions. These questions allowed respondents to express their views on social factors serving as problems for teenagers when seeking information. The last section (fifth section) gave an opportunity for respondents to put forward ***suggestions for prevention*** as a mechanism contributing towards prevention of risky sexual behaviours among teenagers. These two sections had open-ended questions that were particularly meant for exploring the qualitative nature of the study.

Questions under the knowledge section collected information on general basic knowledge of HIV/AIDS (questions 1, 4 and 5), transmission (questions 2 and 3) and prevention (question 6). The questions had options of true, false and unsure options for response. Questions 7 and 8 collected information on the sources of information on HIV/AIDS and question 10 focused on whether respondents talk about HIV/AIDS with their partners. For the true, false and unsure, a score of 1 was allocated for all the correct responses and 2 for all the incorrect responses in relation to the question asked. All unsure responses were automatically allocated the 2 score. Score 1 responses were then considered to have good knowledge of HIV/AIDS and score 2 considered to have poor knowledge of HIV/AIDS.

In the second section, questions 9 and 11 collected information on knowledge of status of partner and self and question 12 collected information on whether participants think their partners are having other relationships. These questions used the yes and no response choices. Other questions on attitudes were based on learners' attitudes towards other people currently known and who have revealed their HIV/AIDS status (question 13) and also enquired about their attitudes (current treatment) towards those people (question 14) and their attitudes (future treatment) should they know someone

who has HIV/AIDS (question 15). Further, questions 16 and 17 enquired about respondents' attitudes towards being infected by HIV themselves and whether they think their family members can be affected by HIV/AIDS respectively. Questions 31 and 32 enquired about decision-making choices in terms of sex from participants.

The third section that focused on sexual behaviour explored learners' engagement in sexual activities (questions 18, 19, 20, 21, 22, 23, 24, 25), the use of condoms for prevention (questions 26, 27, 29 and 30) and reasons for having sex (question 28). Questions 31 and 32 explored gender (both female and male) decision making towards engaging in sexual activities. Question 33 asked participants about the reasons impelling teenagers to have sex.

Questions that were based on social factors in the fourth section were asking about the problems teenagers face when seeking information from clinics (question 34), from parents (question 35), from teachers (question 36) and from other teenagers (question 37). The fifth section finally asked questions seeking suggestions on what should be done by parents (question 38), teachers (question 39), nurses (question 40) and teenagers (question 41) to prevent risky sexual behaviours among teenagers.

5.11 The Process of Data Collection and Questionnaire Administration

The Free State Department of Education was contacted to request permission to conduct this type of study at the two schools and permission was been granted. The school principals subsequently granted permission to conduct the study.

Learners included in the sample were informed and invited to take part in the study and were briefed on how to complete the questionnaire. The ethical conditions and the research purpose of the study were explained to them. Parents of respondents were informed about the proposed participation of their children in the study and were asked for permission using the participants' information sheet (PIS see addendum ii). Participating learners were requested to read the letters for their parents should a need arise.

The researcher employed and trained 6 facilitators (individuals that were not attending school but completed grade 12) to help with questionnaire administration. The questionnaire was group-administered and all facilitators present at the session of completing the questionnaires. Facilitators supervised the whole session (attending to questions seeking clarification) and checked questionnaires for completeness as learners submit and before they could leave.

5.12 Data Analysis

Quantitative data analysis refers to the process of breaking down the data into constituents to obtain answers to research questions and can be done manually or by computer (De Vos et al., 1998:203). Kerlinger (1986) in De Vos et al. (1998:203) further states that the process entails categorising, ordering, manipulating and summarising of data to obtain answers. SPSS (Statistical Programmes for Social Sciences) version 15 and 16 was employed for data capturing and cleaning the collected data and to perform the analysis. Descriptive frequency distributions and cross-tabulations were performed for the analysis of data and establishing the association between independent and dependent variables in order to determine the relationship between knowledge and sexual behaviour of respondents.

5.13 Qualitative Data Analysis for Open-ended Questions

In this study, the approach of Marshall and Rossman (1989:112-120) as identified by Poggenpoel in De Vos et al. (1998:342) was used to analyse data. The following steps were followed as they were believed to best suit the research intentions:

- **Organising the data**

In this step, the researcher familiarised herself with the data that emerged from the open-ended questions through repetitive reading, listing and performing minor editing to make notes retrievable.

- **Generating categories, themes and patterns**

The researcher engaged in creative and analytical thinking as this step requires. Data were grouped into categories and categories that were consistent but distinct from each other within the data were identified. Thus, the themes, patterns and categories were uncovered. Data were grouped using similar colour tags.

- **Searching for alternative explanations of the data**

The researcher used this step to challenge patterns to look for other meanings and explanations of the data. The researcher provided a description and demonstrated why different explanations were offered. This is where data meaning was questioned and other meanings explored.

- **Writing up the findings**

In this step, the results were not merely presented but the researcher continued to interpret and find meaning to the data.

The thematic analysis of the responses to the open-ended questions was **verified by means of peer review** as indicated in Creswell (1998).

5.14 Summary

The quantitative study using a cross-sectional design to explore knowledge, attitudes and behaviour was undertaken among the high school learners of Phahameng. The research tool used was a questionnaire that entailed open-ended questions for the exploration of social factors experienced as problems maintaining risky sexual behaviour among young people in the community and their suggestions towards methods of intervention.

CHAPTER 6: FINDINGS

6.1 Introduction

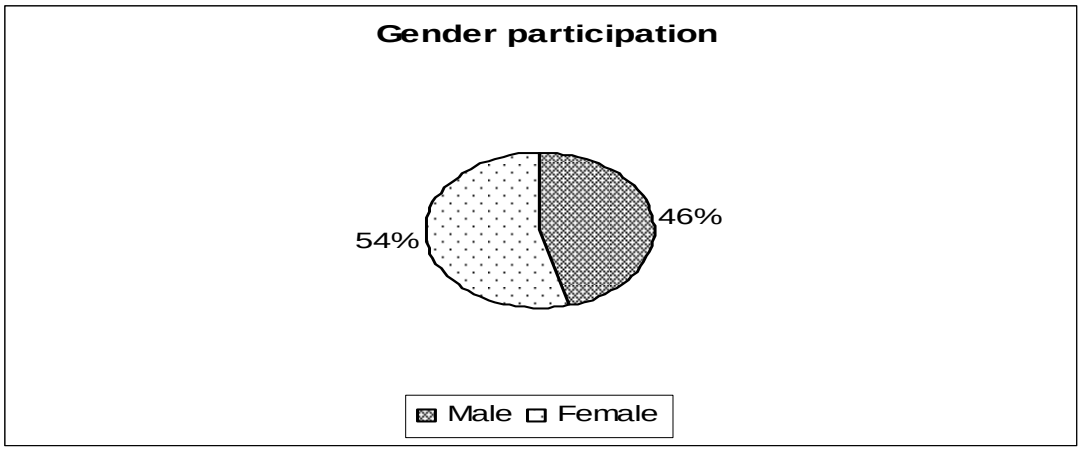
This chapter presents the findings of the study. The demographic details of respondents, i.e., age, gender, grade and language are presented. Findings are presented under key sections of knowledge, attitudes and practices. Cross-tabulations were executed to examine the association between the socio-demographic variables (independent) and knowledge, attitudes and sexual practices variables (dependent). The qualitative findings of a thematic analysis are also presented and, as appropriate for qualitative inductive reasoning, relevant published findings are compared to the findings of the qualitative analysis

6.2 Demographic Details of Learners

This section accounts for the demographic details of learners and presents them according to age, gender, language and grades. The gender, age, language and grades frequencies are shown in table formats below and cross-tabulations are performed to discover the links and patterns of participation. A sample of 462 learners was invited to participate by completing a questionnaire in the study to explore knowledge, attitudes and sexual practices. Out of a total of 462, a total of 303 learners completed questionnaires meaning that a response rate of 65% was obtained.

6.2.1 Gender Participation

Figure 8: Gender Participation



The largest participation rate by gender (Figure 8) was observed among the females who made up to 164 (54%) of the total respondents compared to males who accounted for 139 (46%) participation rate of the total respondents.

6.2.2 Age

Figure 9: Age of Respondents

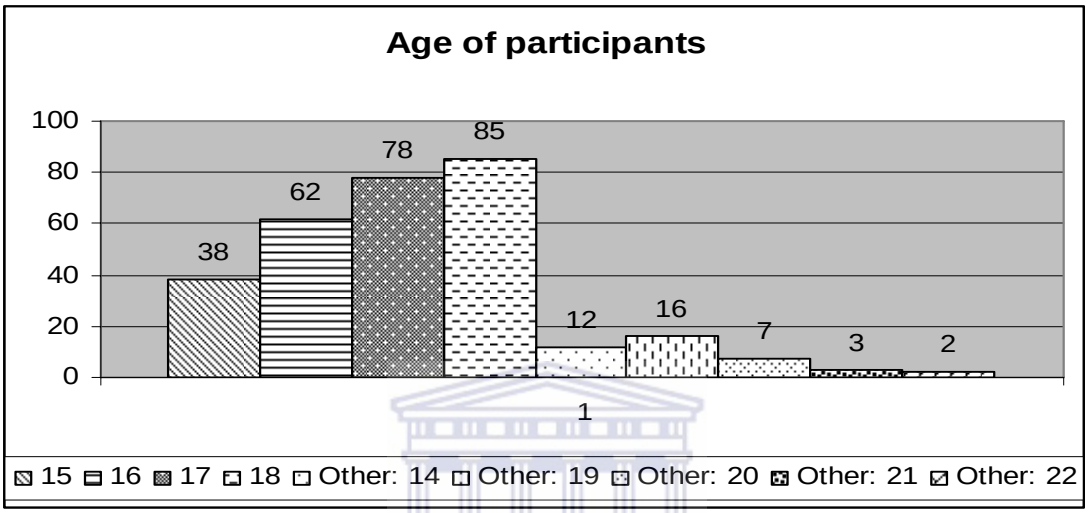


Figure 9 illustrates the distribution of participation by age in the study. The largest participation in terms of age was found among the 18 year olds with a total of 85 (28%), followed by 17 year olds with a total of 78 (26%), 16 year olds with a total of 62 (20%) and the 15 year olds with a total of 38 (13%). Among other ages that participated, the 19 year olds were represented by 16 (5.3%), followed by 14 year olds 12 (4%) and 20 year olds with a total of 7 (2.3%). The lowest participation was observed among the 21 year olds at 3 (1%) and the 22 year olds at 2 (0.7%).

Table 2: Participation of Learners by Age and Gender

Age	**Male**	**%**	**Female**	**%**	**Total**	**%**
15	11	8%	27	16%	38	13%
16	26	19%	36	22%	62	20%
17	32	23%	46	28%	78	26%
18	43	31%	42	26%	85	28%
Other	27	19%	13	8%	40	13%
Total	**139**	**100%**	**164**	**100%**	**303**	**100%**
Total % by gender	46%		54%			

The above table (table 2) is an indication of participation of learners by age and gender and provides the numerical summary of the discussion presented in 6.2.1 and 6.2.2 above.

6.2.3 School Grades

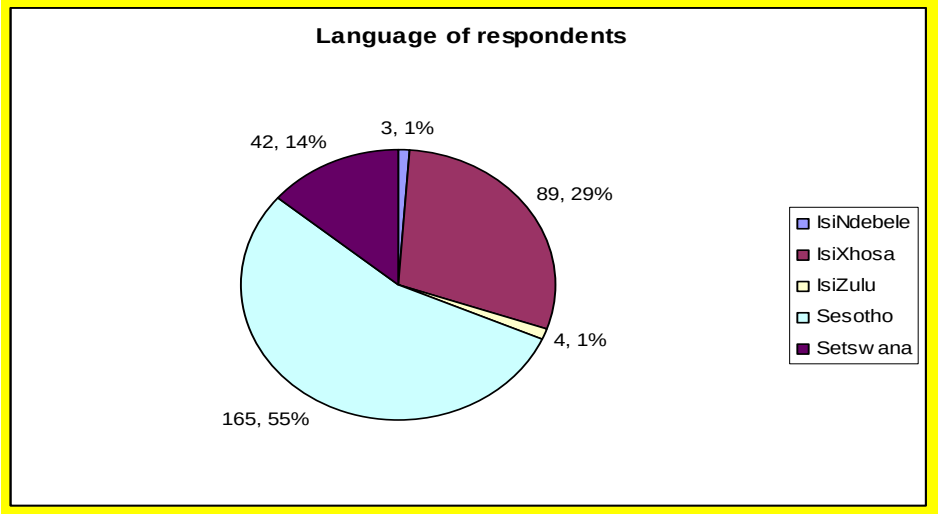
Table 3: Participation by Gender and School Grades

Gender	**Grade 9**	**%**	**Grade 10**	**%**	**Grade 11**	**%**	**Grand Total**
Male	34	45%	55	44%	50	49%	139
Female	42	55%	69	56%	53	51%	164
Total	76	100%	124	100%	103	100%	303
Total %	**25%**		**41%**		**34%**		
	Grade 9 % within the grand total of 139 male/ 164 female category		**Grade 10 % within the grand total of 139 male/164 female category**		**Grade 11 % within the grand total of 139 male/164 female category**		
Male	24% n=34		40% n=55		36% n=50		
Female	26% n=42		42% n=69		32% n=53		

Looking at the participation by school grades (table 3), 124 grade 10 learners (41%) gave the highest participation rate followed by 103 grade 11 learners (34%) and 76 grade 9 learners (25%). A closer view on the participation by gender within school grades presented that higher percentages of participation were obtained among female respondents within the grade 10 learners (42%) followed by male respondents (40%) within the same grade. Male respondents in the Grade 11 outperformed females by giving 36% participation and females giving 32% participation.

6.2.4 Home Language of Respondents

Figure 10: Home Language of Respondents



Respondents indicated Sesotho as the mainly used home language (55%), followed by IsiXhosa (29%) and Setswana (14%). The use of isiZulu and isiNdebele is just by 1%. For the reason of Sesotho dominating other languages, the language variable could not provide opportunity for proper analysis to take effect and was therefore omitted.

6.3 HIV/AIDS Knowledge and Communication

This part reports the knowledge of HIV/AIDS among respondents and how they communicate about the pandemic. Learner knowledge was divided into sub-categories of general basic knowledge, HIV/AIDS transmission and HIV/AIDS prevention. Table 4 below indicate the grouping of variables for conditions to satisfy sub-category responses in knowledge.

Table 4: Measurement of Concepts

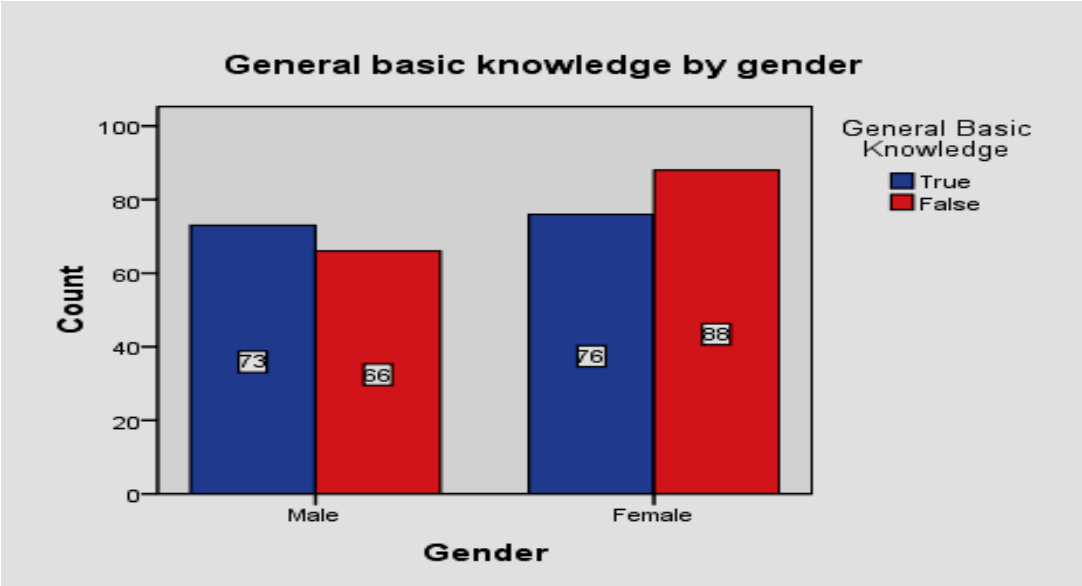
Category	Sub-category	Related questions	Correct answer and numeric score
Knowledge	Basic Knowledge of HIV/AIDS	1.1 Only children can get HIV/AIDS	False [2]
		1.2 Only young people can get HIV/AIDS	False [2]
		1.3 Only adults can get HIV/AIDS	False [2]
		1.4 Anybody can get HIV/AIDS	True [1]
		4. A healthy looking person can be carrying HIV	True [1]
		5. There is cure for HIV/AIDS	False [2]
	Transmission	2.1 Shaking hands with a HIV+ person	False [2]
		2.2 Sharing eating utensils with a HIV+ person	False [2]
		2.3 Sharing toilet facilities with a HIV+ person	False [2]
		2.4 Eating food prepared by HIV infected people	False [2]
		2.5 Kissing somebody who is infected and has no open sores in the mouth	False [2]
		2.6 Having unprotected sex	True [1]

		2.7 Having blood contact with the blood of an infected person	True [1]
		3.1 An infected mother during pregnancy to her unborn baby	True [1]
		3.2 An infected mother to her baby during childbirth	True [1]
		3.3 An infected mother through breastfeeding	True [1]
	Prevention	6.1 Abstaining from sex	True [1]
		6.2 Using condoms	True [1]
		6.3 Avoiding eating with others	False [2]
		6.4 Not shaking hands	False [2]
		6.5 Avoiding HIV infected blood	True [1]
		6.6 Having sex with a virgin	False [2]

6.3.1 General Basic Knowledge of HIV/AIDS

This sub-category was used to measure the HIV/AIDS general basic knowledge of learners using questions 1, 4 and 5. The main question asked under question 1 was "Who can get HIV/AIDS" and four options were assigned to the question using the true, false and unsure response measures. Questions 4 and 5 were statements that enquired whether "a healthy looking person can be carrying HIV" and "there is cure for HIV/AIDS" respectively using the true, false and unsure responses. For the condition to be satisfied, responses under general basic knowledge had to follow the sequence of F, F, F, T, T and F (see table 4 above). All the responses that satisfied this condition were allocated a score of 1 (true) and all other responses that did not satisfy the condition were allocated a score of 2 (false).

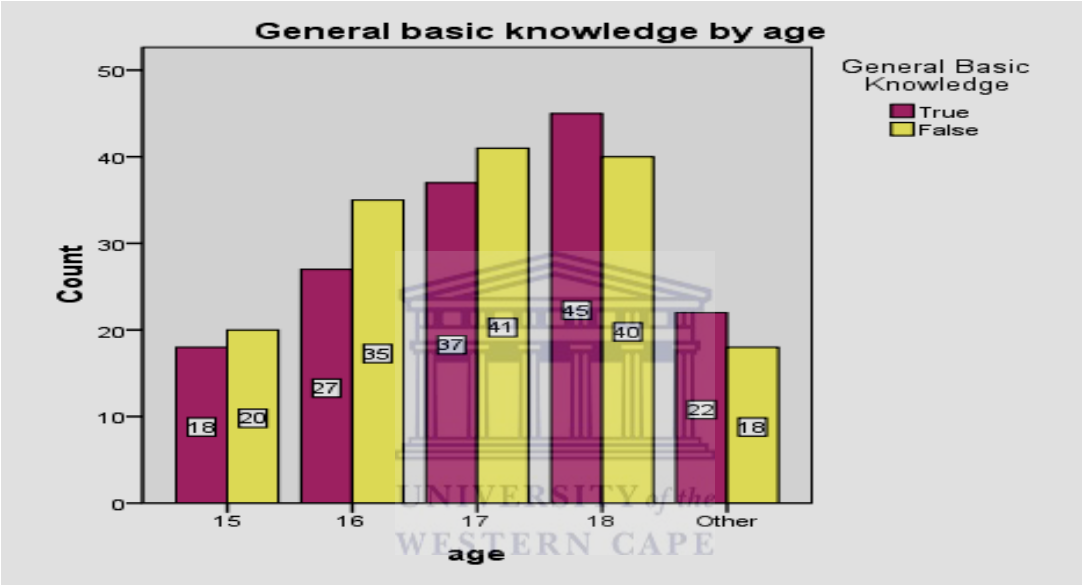
Figure 11: General Basic Knowledge and Gender



In terms of gender (figure 11), it was found that:

- 149 (49%) of respondents had good knowledge on general basic knowledge of HIV/AIDS among which 49% were male and 51% were female participants.
- 154 (51%) of respondents had poor knowledge on general basic knowledge of HIV/AIDS, 43% of them being male and 57% being females.

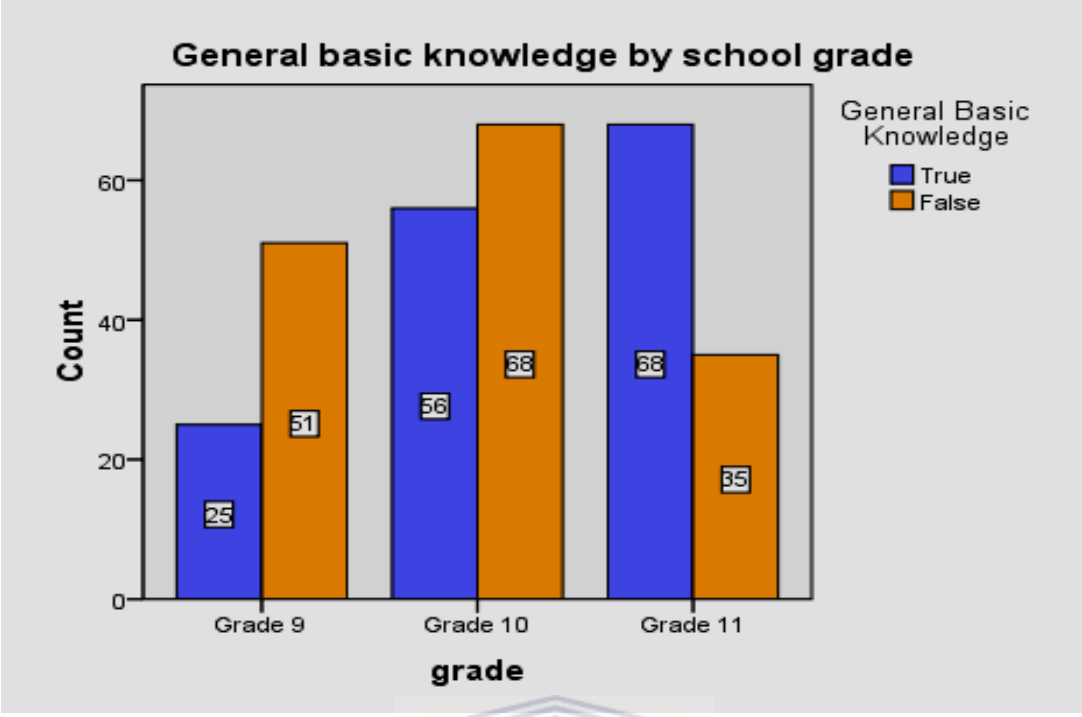
Figure 12: General Basic Knowledge and Age



With regards to age (figure 12), a total of 149 (49%) of respondents had good knowledge of general basic knowledge of HIV/AIDS and 154 (51%) had poor knowledge. A breakdown by age groups indicates that 15% of the good knowledge total lies within the 18 year olds age group. This is the highest percentage given followed by the 17 year olds (12%), 16 year olds (9%) and other age groups by 7%. The 15 year olds ranked the lowest with 6% of good basic knowledge indicated amongst all other age groups.

For the poor basic knowledge of HIV/AIDS, the 17, 18 and 16 year olds had 1% differences between them with 14%, 13% and 12% respectively. The 15 year olds (7%) also differed from the 'other age group' (6%) by 1%.

Figure 13: General Basic Knowledge by School Grade



Analysis looking at the general basic knowledge by school grades presented the same results in terms of total good and poor basic knowledge of HIV/AIDS (49% true and 51% false). Figure 13 is an indication of value labels of the results. The highest good basic knowledge percentages were obtained by the grade 11 learners with 22%, followed by grade 10 learners with 19% and lastly the grade 9 learners with 8%.

In terms of the poor basic knowledge among learners, grade 10 respondents had 22% followed by the grade 9 learners who had 17% and grade 11's having 12%.

6.3.2 HIV/AIDS Transmission

The sub-category of transmission was aimed at exploring respondents' knowledge of HIV/AIDS transmission. Questions 2 and 3 were used to measure respondents' knowledge with regards to transmission. Both questions add up to 10 response options requiring a true, false and unsure response measures. For the condition to be satisfied (good knowledge of transmission), responses under transmission had to follow the sequence of F, F, F, F, F, T, T, T, T, and T (see table 4). All the responses that satisfied this condition were allocated a score of 1 and all other responses that did not

satisfy the condition were allocated a score of 2. The following results were found:

- 59 (19%) of respondents had good knowledge of how HIV/AIDS is transmitted.
- 244 (81%) of respondents had poor knowledge of how HIV/AIDS is transmitted.

The good knowledge of transmission findings in terms of gender, age and school grade presents the following:

- Of the 19% found, 10% is male and 9% is female respondents.
- This good knowledge lies among the 18 year olds by 7% followed by 17 year olds by 5%.
- Percentages in terms of grade rank by 9% for grade 11's, 8% for grade 10's and 2% for grade 9's.

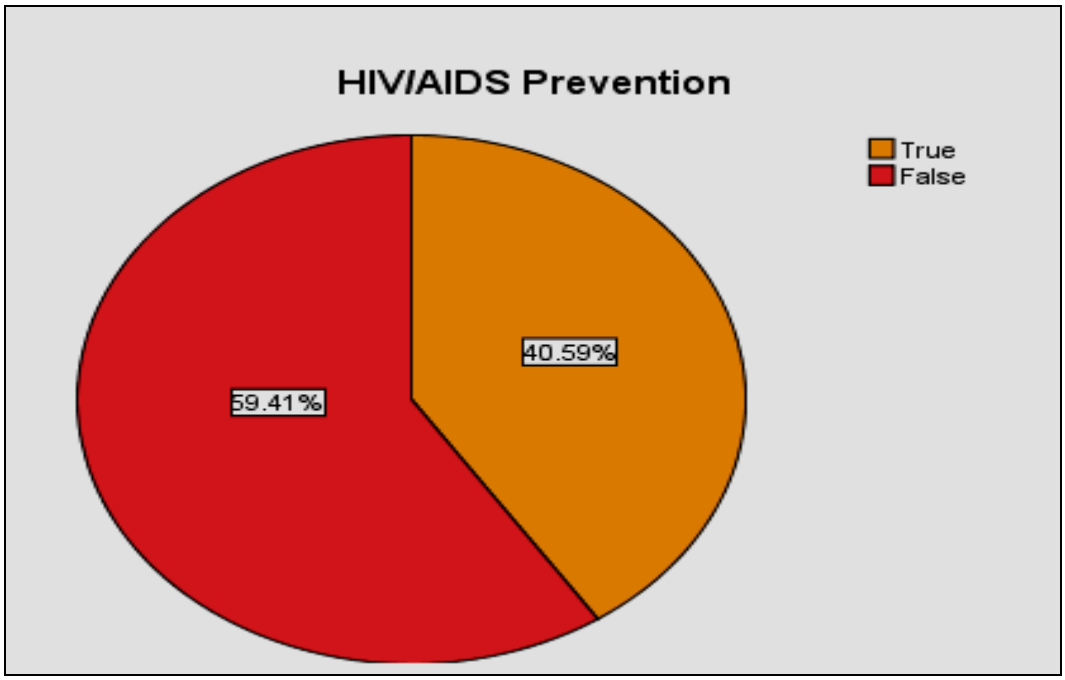
The poor knowledge of transmission by gender, age and school grade indicates:

- 36% of respondents were males and 45% were females.
- 21% was among both the 17 and 18 year olds respondents followed by 18% of 16 year olds, 11% of other ages and 10% of the 15 year olds.
- 33% is among the grade 10's, followed by 25% of grade 11's and 23% of grade 9's.

6.3.3 HIV/AIDS Prevention

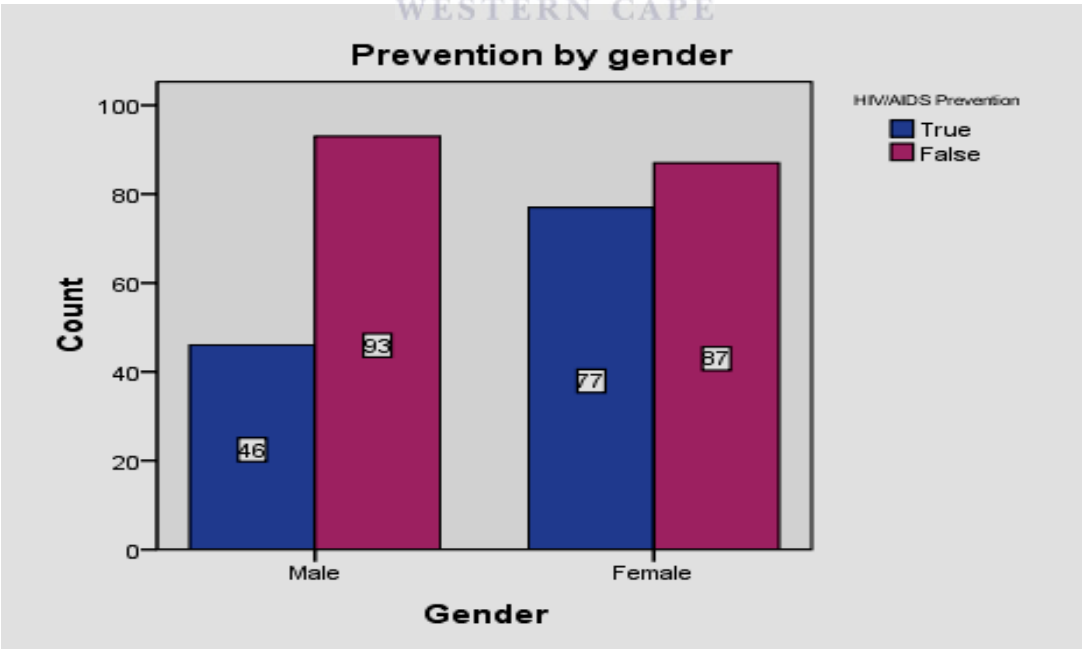
This sub-category of HIV/AIDS prevention was to explore respondents' knowledge of prevention. Question 6 which had 6 options, was used to measure respondents' knowledge of prevention. For the condition to be satisfied, responses under prevention had to follow the sequence of T, T, F, F, T and F (see table 4). All the responses that satisfied this condition were allocated a score of 1 and all other responses that did not satisfy the condition were allocated a score of 2.

Figure 14: HIV/AIDS Prevention



From the analysis, it became clear that 123 (41%) of respondents had good knowledge of prevention as compared to 180 (59%) respondents who had poor knowledge of prevention (figure 14).

Figure 15: Knowledge of Prevention and Gender



An analysis of respondents' knowledge of prevention by gender gave the following results (figure 15 above):

From the total of 41% among respondents regarded as having good knowledge of prevention, 15.2% were male respondents and 25.4% were females. This could mean that more females than males have good knowledge of how HIV/AIDS can be prevented.

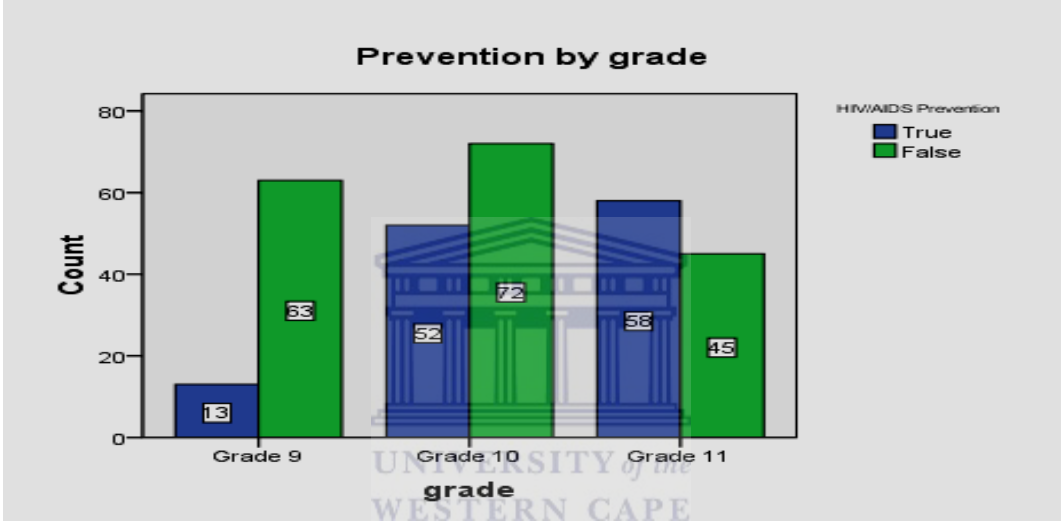
Among the 59% of those having poor knowledge of prevention of the pandemic, 30.7% were male respondents and 28.7% were female respondents. The poor knowledge percentages are higher than those with good knowledge of prevention. It could therefore be deduced that both male and female respondents generally have poor rather than good knowledge of prevention. Although there is a minor percentage difference between the male and female poor knowledge group, it is important to note that male respondents rank higher than females in terms of having poor knowledge of how the disease can be prevented. Therefore, taking into consideration that the percentage of male respondents was lower than that of females with regards to good knowledge, it could be concluded that respondents in general had poor knowledge of prevention, but the percentage of male respondents with that poor knowledge, are higher than that of females.

Table 5: Age and HIV/AIDS Prevention Cross-tabulation

Age		HIV/AIDS Prevention		
		True	False	Total
15	Count	12	26	38
	% within age	31.6%	68.4%	100.0%
	% of Total	4.0%	8.6%	12.5%
16	Count	28	34	62
	% within age	45.2%	54.8%	100.0%
	% of Total	9.2%	11.2%	20.5%
17	Count	32	46	78
	% within age	41.0%	59.0%	100.0%
	% of Total	10.6%	15.2%	25.7%
18	Count	35	50	85
	% within age	41.2%	58.8%	100.0%
	% of Total	11.6%	16.5%	28.1%
Other	Count	16	24	40
	% within age	40.0%	60.0%	100.0%
	% of Total	5.3%	7.9%	13.2%
Total	Count	123	180	303
	% within age	40.6%	59.4%	100.0%
	% of Total	40.6%	59.4%	100.0%

An age analysis with regard to knowledge of prevention shows that all age groups have a poor knowledge rather than a good knowledge; both on proportion and percentage, i.e., 59% as opposed to 41% respectively (see Table 5). The reported poor knowledge group lies mostly among the 18 year olds (17%), followed by 17 year olds 46 (15%), the 16 year olds 34 (11%) and the 15 year olds by 26 (9%). Other age groups contribute 7% towards the poor knowledge.

Figure 16: Knowledge of Prevention and School Grade



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With regards to school grade, figure 16 illustrates that good knowledge levels for prevention (19.1%) are found only among the grade 11's where the percentages are higher than those with poor knowledge (14.9%). Both the grade 9 and 10 respondents had higher percentages of poor knowledge of prevention (20.8% and 23.8% respectively) than those with good knowledge of prevention (4.3% and 17.2% respectively). It can be concluded that even although the percentage of respondents with a poor knowledge of prevention (59%) is higher than those with a good knowledge of prevention (41%), the grade 11 respondents had a better knowledge as compared to other grades

6.3.4 Communication

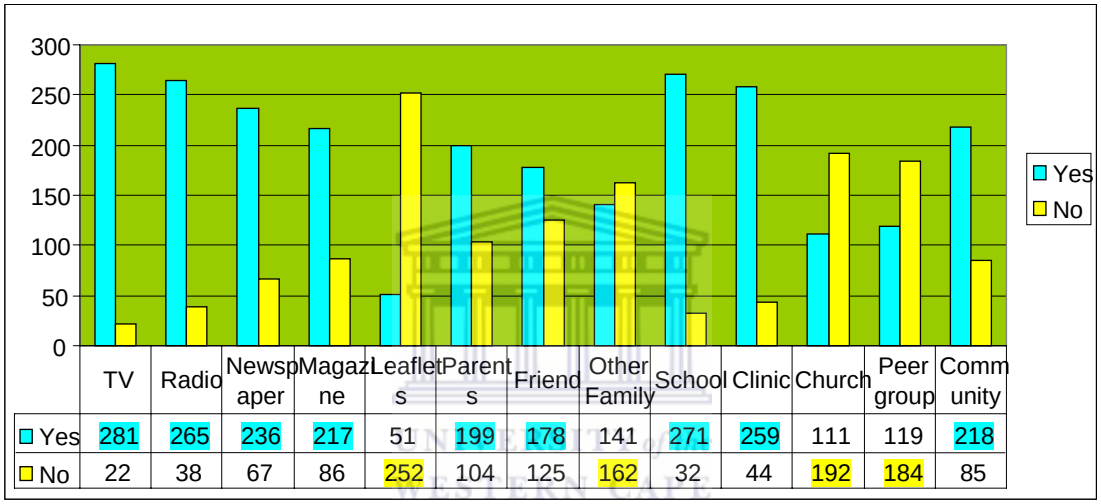
Questions 7, 8 and 10 were used to determine the manner in which learners communicate about HIV/AIDS. Question 7 examines various sources of

getting information on HIV/AIDS and question 8 explored whether or not getting information about HIV/AIDS is easy. Question 10 was meant to explore the degree of communication between respondents and their partners.

6.3.4.1 Sources of Information about HIV/AIDS

Figure 17 reports on the various sources indicated by respondents where information about HIV/AIDS is readily available.

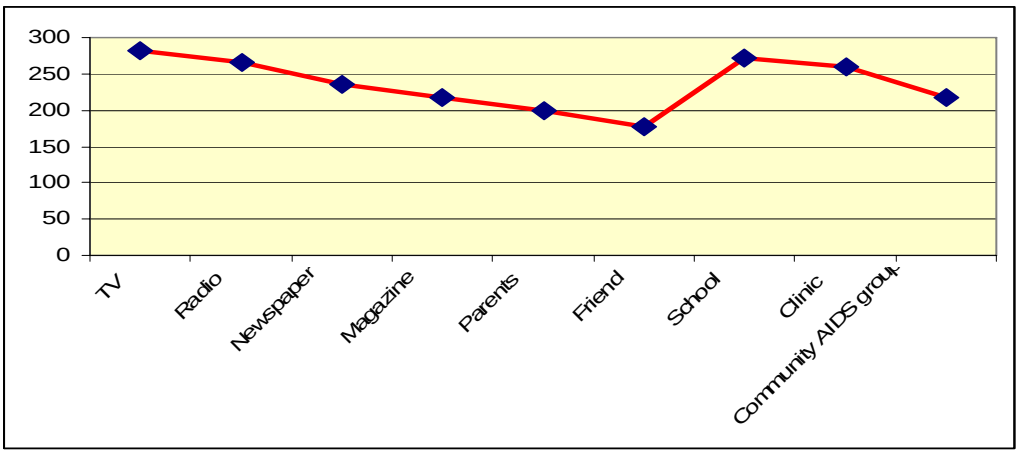
Figure 17: Sources of obtaining information about HIV/AIDS



	TV	Radio	Newspaper	Magazine	Leaflets	Parents	Friend	Other Family	School	Clinic	Church	Peer group	Community
Yes	281	265	236	217	51	199	178	141	271	259	111	119	218
No	22	38	67	86	252	104	125	162	32	44	192	184	85

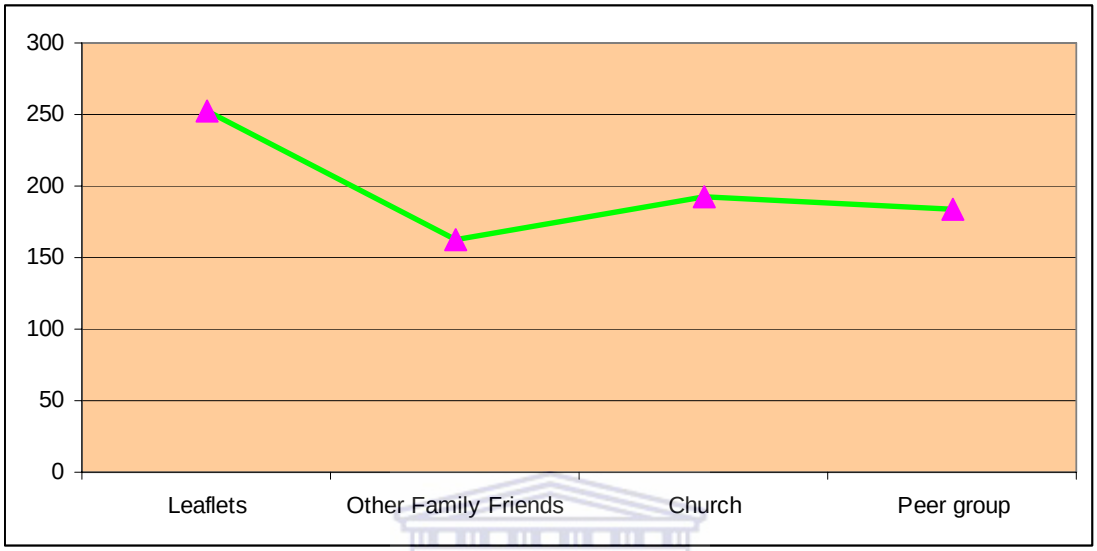
Television ranks high among the sources that provided information as indicated by respondents, followed by the school, radio, clinic, newspaper, the community AIDS group, magazine, parents and friends (figure 18).

Figure 18: Sources of information by rank of providing information



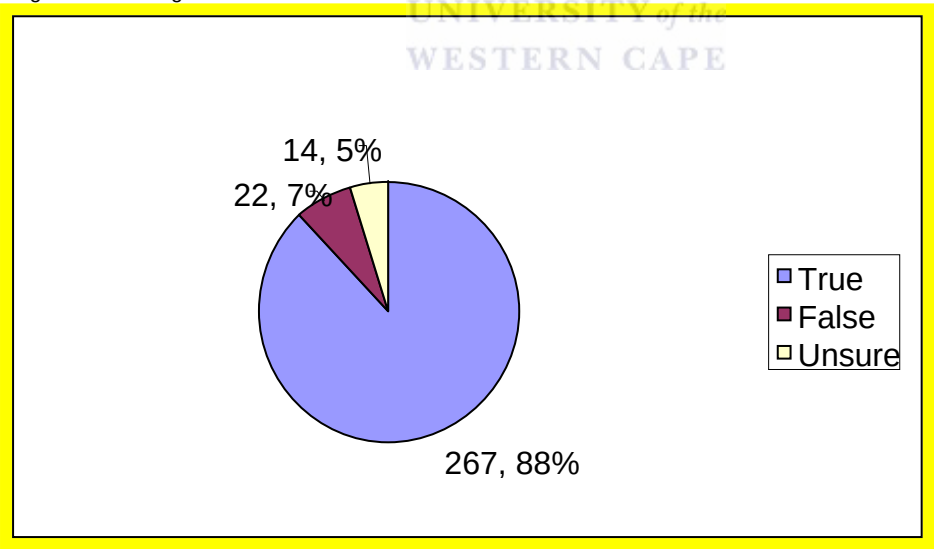
Among the sources chosen to have provided less information on HIV/AIDS are leaflets, church, peer group, other family members, friends and parents (figure 19).

Figure 19: Sources that provide less information by rank



6.3.4.2 Getting Information is Easy

Figure 20: Getting Information



The majority of respondents 267 (88%) indicated that getting information about HIV/AIDS is easy. Only 22 (7%) of the respondents felt that it is not easy to obtain information and 14 (5%) was unsure. A comment can be made at this point that as the majority of respondents indicated that getting information about HIV/AIDS is easy, it is an indication that obtaining

information relies more on the role played by available sources of information than on the difficulty to obtain it.

6.3.4.3 Talking about HIV/AIDS with Partners

This part is aimed at exploring whether communication about HIV/AIDS takes place among respondents and their partners. The majority of respondents 195 (65%) indicated that they do talk about HIV/AIDS with their partners as compared to 105 (35%) that indicated that they don't talk about HIV/AIDS with their partners.

From the 65% of those who do talk about HIV/AIDS with their partners, analysis indicated the following:

- 93 (31%) are male participants and 102 (34%) are female respondents.
- 82 (27%) are found among the grade 10's, followed by 77 (26%) of grade 11's and 36 (12%) of grade 9's.
- It is among the 18 year olds (62 or 21%) that talking about HIV/AIDS with partners happens most frequently, followed by the 17 year olds (46 or 15%), and the 16 year olds by (39 or 13%). Talking about HIV/AIDS is less frequent among other age groups (27 or 9%) and the 15 year olds (21 or 7%).

Of the 35% who do not talk about HIV/AIDS with their partners, the following results emerged:

- 46 (15%) are males and 59 (20%) are females;
- Both the grade 9 and 10 are indicated by 13% and the grade 11's by 9%;
- 11% is the highest percentage indicated by the 17 year olds and the rest of age groups are below 8%.

To summarise, there is an overall indication that knowledge of HIV/AIDS in terms of the general basic knowledge, transmission and prevention categories defined for analysis, is lacking among respondents. The poor knowledge could be interpreted as having limited knowledge about the pandemic and varies considerably by genders, ages and school grade groups. Research in terms of the how information is acquired indicates that information is available

through different sources and that it is easily available. The question remains whether respondents were serious about absorbing and using this information correctly.

6.4 Attitudes in Relation to HIV/AIDS

The attitudes section was aimed at determining the attitudes of learners towards HIV/AIDS infection. Questions 9 and 11 explored respondents' knowledge of their own statuses and that of their partners and question 12 focused on determining whether or not respondents thought their partners were having other relationships. Question 13, 14, 15, 16 and 17 explored learners' attitudes towards other people currently known and whether they have revealed their HIV/AIDS status; their attitudes (current treatment) towards those people; and their attitudes (future treatment) should they meet someone who has HIV/AIDS; and respondents' attitudes towards being infected by HIV themselves and whether they thought their family members could be affected by HIV/AIDS respectively. Questions 31 and 32 looked at the attitudes of respondents with regards to making decisions about sex.

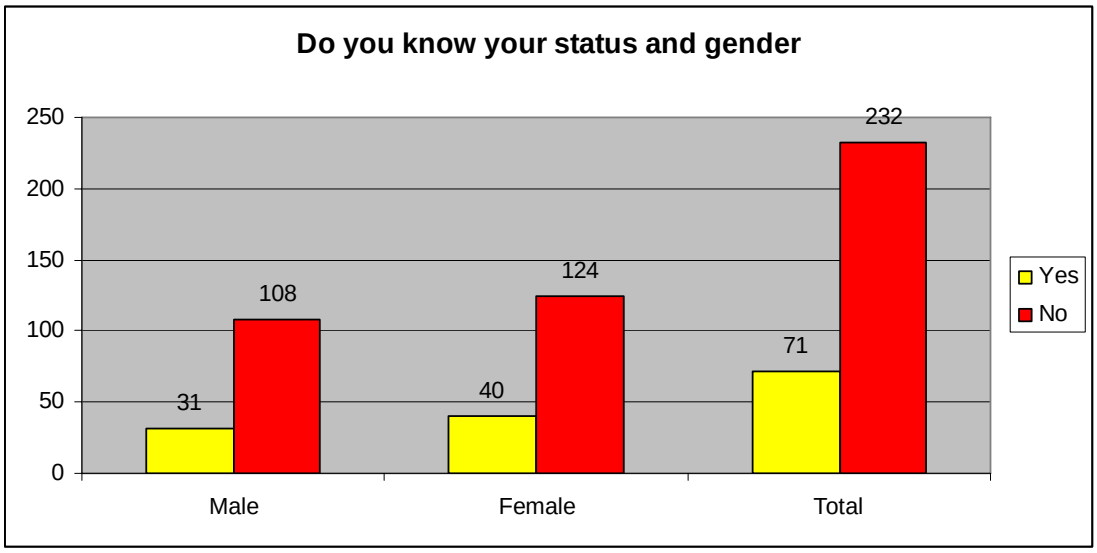
6.4.1 Status Knowledge and Other Relationships of Partners

Respondents' knowledge of their own statuses and that of their partners, as well as whether they thought their were having other relationships, could serve as important indicators for attitudes as it could help determine the level of perceived risk of infection.

6.4.1.1 Status Knowledge of Self

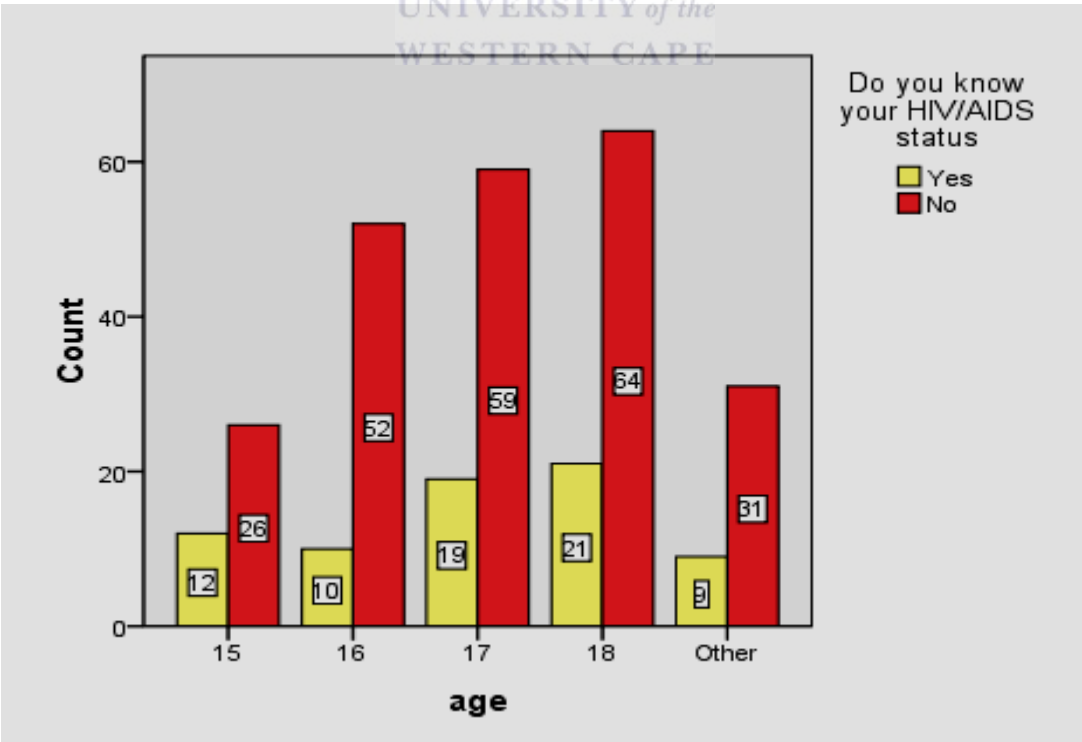
Figure 21 displays the results that emerged from the question of whether respondents knew their HIV/AIDS statuses and comparisons are made between gender, age and grades. A total count of 71 (23%) of respondents indicated that they knew their HIV/AIDS statuses compared to 232 (77%) of respondents who indicated that they do not know their HIV/AIDS statuses. This means that the majority of respondents disregard of gender, age and school grade did not know their HIV/AIDS statuses.

Figure 21: Knowledge of Status by Gender



Comparisons by gender and “do you know your HIV/AIDS status” revealed that of the 23% of respondents that knew their statuses, 13% were females while 10% were males. Of the 77% that did not know their statuses, 36% were males and 41% were females, indicating that more females than males did not know their statuses.

Figure 22: Knowledge of Status and Age



When looking at the age of respondents and knowledge of their statuses (figure 22), the following can be highlighted:

- Of the 23% that knew their statuses, the highest number is among the 18 year olds, namely 21 (7%), followed by the 17 year olds with a number of 19 (6%);
- Of the 77% that did not know their statuses,18 year and 17 year olds ranked the highest by 64 (21%) and 59 (20%) respectively, followed by the 16 year olds 52 (17%). Other and the 15 year olds ranked the lowest by 31 (10%) and 26 (9%) respectively.

With regards to respondents' knowledge of their own statuses and school grades, results indicated that 11% was the highest percentage of all reported amongst the grade 10 respondents that knew their statuses. Both grades 9 and 11 reported percentages below 7% in this category. The majority of respondents that did not know their statuses are among the grade 10 respondents (30%), followed by the grade 11 respondents (27%) and the grade 9 respondents (20%).

6.4.1.2 Status Knowledge of Partner

Respondents were asked whether they knew the HIV/AIDS statuses of their partners. From the total of all respondents, the majority of 250 (84%) indicated that they did not know their partner statuses and both male and female respondents were largely implicated (41% and 43% respectively). This finding was opposed to only a few respondents 48 (16%) that did say they knew their partner statuses. Of these respondents, 5% were males and 11% were females.

High percentages were present among the 18 and 17 year olds, both attaining 23% each, followed by the 16 year olds with 19% and other age groups with 11%. The 15 year olds reported the lowest findings of 8% with regards to not knowing their partner's status.

In terms of school grades, it was among the grade 10's that the highest percentages were observed, namely 99 (33%), followed by the grade 11's 84 (28%) and the grade 9's 67 (23%).

Comparisons between respondents' knowledge of their own statuses and that of their partner's, presented results not far different from both proportionally and by percentage. No conclusions can be made at this point as we do not know whether there are sexual engagements of any kind taking place between respondents and their partners.

6.4.1.3 Partner Relationships

Respondents were asked whether they think their partners are having other relationships or not. Results indicated high percentages of respondents who did not think that their partners were having other relationships 219 (74%) as opposed to 76 (26%) who thought their partners were having other relationships.

6.4.2 Perceived Risk of Infection

In terms of being infected, only 137 (45%) of respondents thought that they could be infected with HIV/AIDS as compared to 163 (54%) who didn't think that they could be infected. Just a small number of respondents 3 (1%) did not respond to the question.

When enquired about whether their family members could be affected by HIV/AIDS, a total of 193 (64%) of respondents thought that their family members could be affected by HIV/AIDS and 110 (36%) thought that their family members could not be affected by HIV/AIDS.

6.4.3 Knowledge of People who revealed their Status

On the question of knowledge of people who revealed their statuses, 150 (49%) of respondents indicated that they did know such people as compared to 153 (51%) who didn't know such people. Subsequent to knowledge of people who revealed their statuses, was a question of how they would treat them if they currently knew them and how they would treat them in future in

cases where they didn't know them currently. Of those who currently knew someone who revealed an HIV/AIDS status, the following was found:

- 31 (10%) indicated that they avoid such people as they do not know how to treat them and
- 116 (38%) indicated that they accept such people the same as other people in the community.
- A small number, below 2%, reported that they avoid these people because did not want to be associated with them or because of being afraid to be in contact with HIV/AIDS infected people.

Among those who currently did not know people who revealed their statuses and what their treatment would be should they know them in future, it was found that:

- 23 (8%) said they would avoid such people because they wouldn't know how to treat them and
- 112 (37%) said they would accept such people just like anybody else in the community.
- Only a total of 5 (2%) indicated that they would avoid such people because of not wanting to be associated with HIV/AIDS infected people.
- A total of 11 (4%) indicated that they would avoid people infected with HIV/AIDS should they know them in future due to being afraid of infected people.

In general, it can be reported that respondents had a positive attitude towards people currently known to be infected and those that may be infected in future. This is based on the high response rate that indicated respondents' current and future willingness of acceptance of infected people. It is, however, important to note those percentages below 4 in general that indicated current and future avoidance because of not wanting to be associated with infected people or being afraid of infected people.

6.4.4 Decision Making about Sex in Relationships

Question 31 and 32 (see addendum iii) explored what respondents thought in terms of male and female's decisions about sex.

In relation to the question whether it is okay for women to say no to sex, 232 (77%) indicated yes as opposed to 71 (23%) that said no. Of those who said yes, 95 (31%) were males and 137 (45%) were females.

With regards to the question whether it is okay for men to say no to sex, 217 (72%) said yes as opposed to 86 (28%) that indicated no. Within the percentage that indicated yes, 89 (30%) were males and 128 (42%) were females.

It can be reported that although there is a general consensus that both male and females can say no to sex, females voted higher for both males and females than males on saying yes to both questions.

6.5 Sexual Behaviour

6.5.1 Learners' levels of engagements in sexual activities

This section focused on respondents' engagement in sexual activities. Questions 18, 19, 20, 21, 22, 23, 24 and 25 were used to explore respondents' engagements in sexual activities and the risks patterns. In particular, question 18 explored whether respondents ever had sex. From question 19, questioning focused on respondents that indicated they had sex and excluded all those that said they have not had sex yet. These questions explored age at first sex, sex of partner, whether they continue having sex, frequency of having sex, with how many partners they have sex, when was the last time to have sex and whether partner was known at last time of having sex.

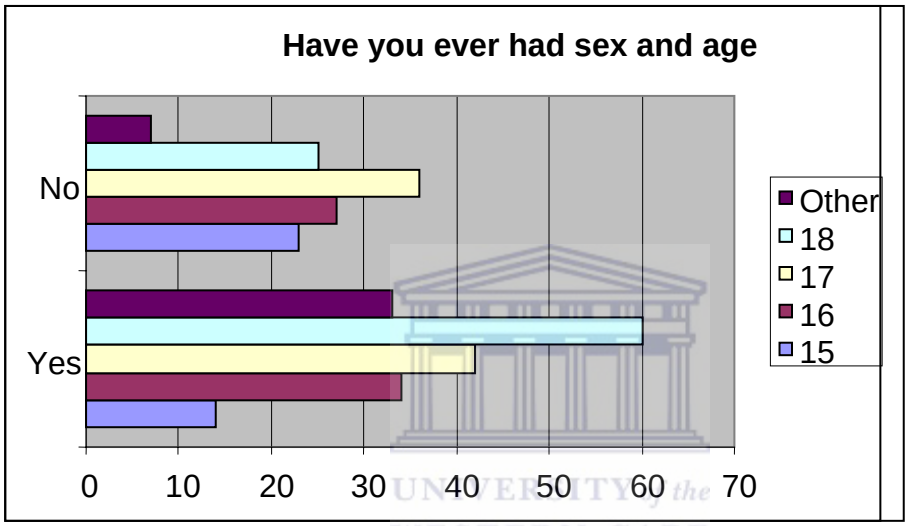
6.5.1.1 Sexual Experience

Respondents were asked a question on whether they ever had sex. In total, most respondents 182 (60%) reported that they had sex whilst 121 (40%) had not. Comparisons in terms of gender, age and school grade of respondents

were made in relation to this question. In terms of gender, the following results were found:

- A total of 103 (74%) of males had sex as opposed to 36 (26%) who did not;
- A total of 80 (49%) of females had sex as opposed to 84 (51%) who did not;
- More males 103 (56%) had sex than females 80 (44%).

Figure 23: Ever had Sex and Age



Comparisons amongst the age groups (figure 23 above) revealed that the highest number of those that indicated they had sex was among the 18 years old 60 (33%), followed by the 17 years old 42 (23%) and the 16 years old 34 (19%). The other age group is indicated by 33 (18%) and it covered the ages below 15 and over 18 years. Among the age group of 15, only 13 (7%) of respondents indicated that they had sex. These results are based on the total number of 182 respondents that indicated they had sex.

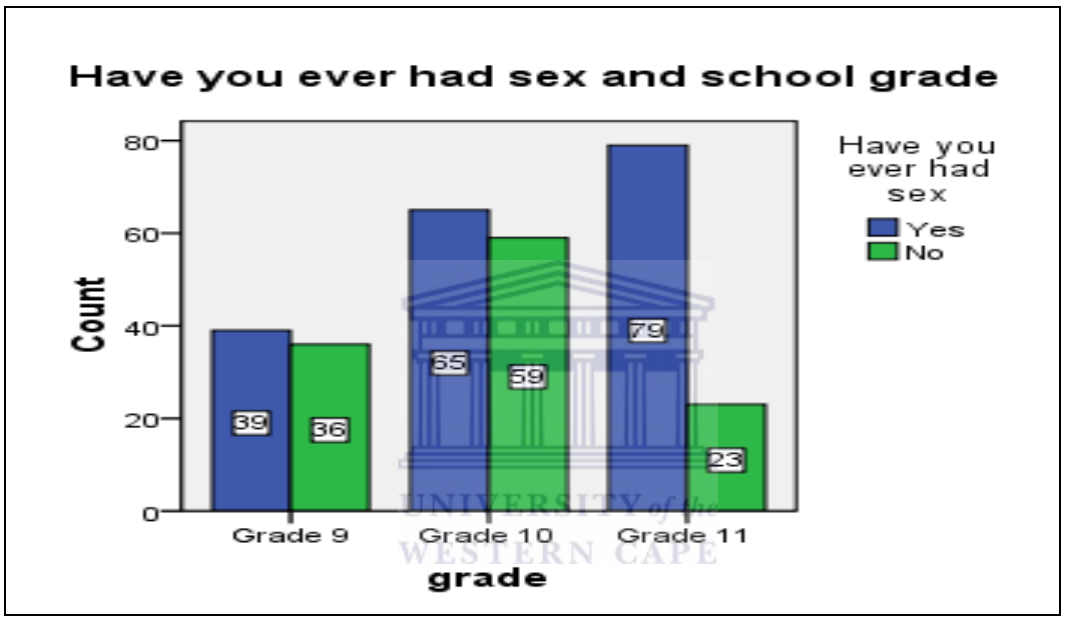
Of those who had not had sex, the highest numbers are among the 17 years old 36 (30%), followed by the 16 year olds 28 (23%), the 18 years old 25 (21%) and the 15 years old 25 (21%).

It is important to note that there was a 12% gap among the 15 years old that indicated they had sex and those that have not. This could mean that sexual

activities among the 15 years old are currently not rife as compared to other age groups, especially the 18 year olds.

In terms of the school grades, the comparison between those who had sex and those who had not, revealed that the lowest counts 23 (20%) was observed amongst the grade 11's; followed by the grade 9's with 36 (30%) and the grade 10's with 59 (50%).

Figure 24: Ever had Sex and School Grade



Statistical count increases within the grades were observed amongst those who had sex (Figure 24). The greatest count increase was among the grade 11's who had the highest count of 79 (43%), followed by the grade 10's with 65 (36%) and lastly the grade 9's with 39 (21%). One can infer that as the learners progress with grades, they become much more sexually active than whilst in lower grades.

6.5.1.2 Age at First Sex and Sex of Partner

Figure 25: Age at First Sex and Gender

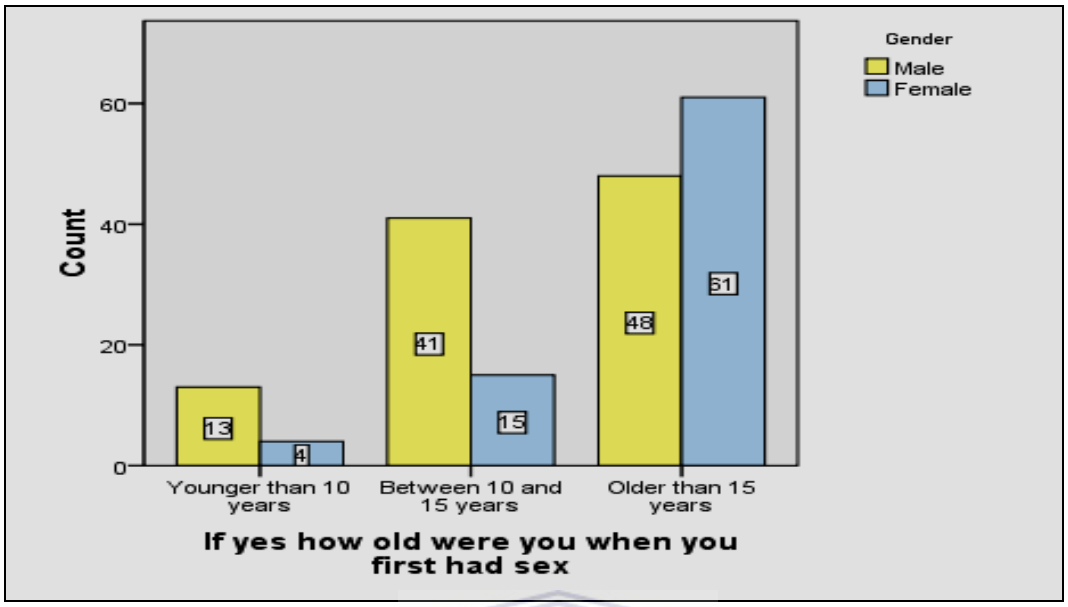


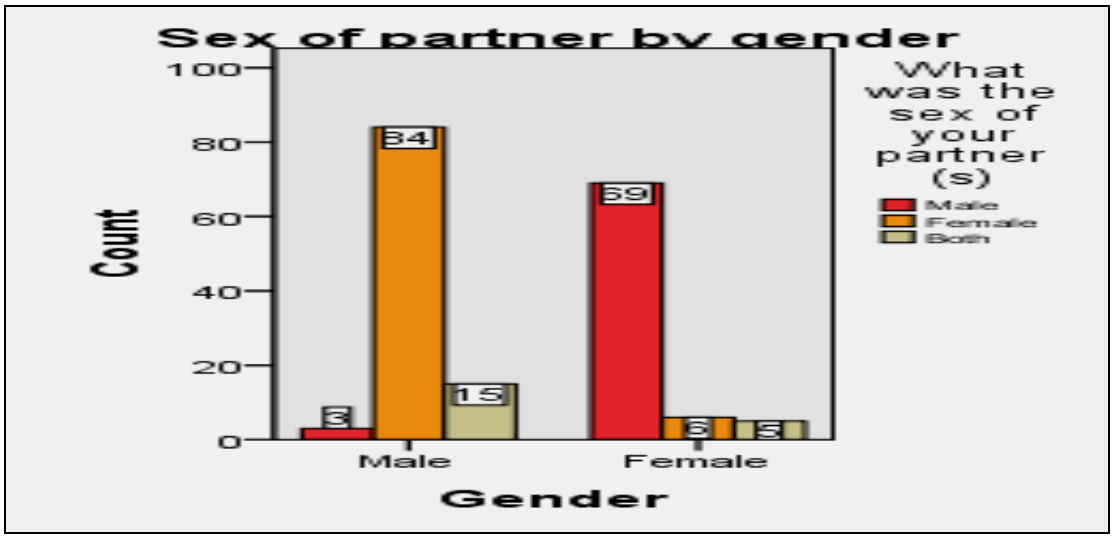
Figure 25 displays the age at first sex among those who indicated that they had sex. Males generally initiated sex at younger ages than females and the pattern is constant for between 10 and 15 years and younger than 10 years. Most females indicated that their age at first sex was when they were older than 15 years. The average age at first sex for all respondents was 15 years.

Within the male category, a small number of respondents had sex when they were younger than 10. There was a greater increase observed as the age increased and minor count differences were observed within the ages between 10 and 15 and older than 15.

Although increase with age was observed amongst the female respondents, the number for those that had sex whilst younger than 10 years was three times lower than that of males.

It is clear from the above discussion that male initiation of sex was much more vigorous at an early age and by the time they became older than 15, they have had sex 5 times more than females.

Figure 26: Sex of Partner by Gender



On exploring sex of the partner at first sex, most sexual practices among males and females (an average of 84%) were reported to be heterosexual. Among males,

- 84 (82%) indicated having had sex with females;
- 3 (3%) had sex with other males;
- 15 (15%) had sex with both sexes.

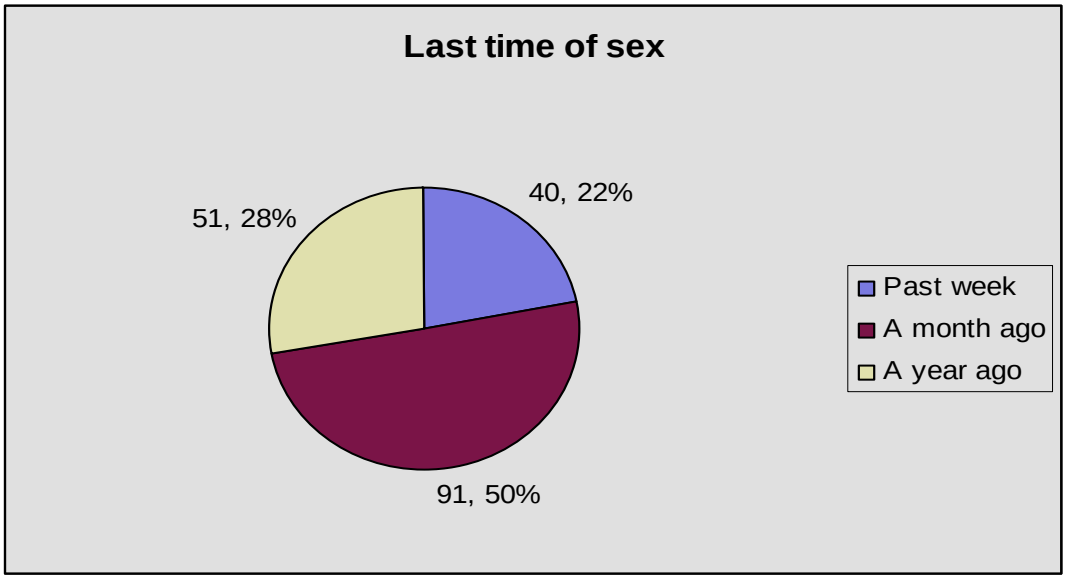
Among females,

- 69 (86%) indicated having had sex with males;
- 6 (8%) had sex with other females;
- 5 (6%) had sex with both sexes.

6.5.1.3 Last Time of Sex

Respondents were asked to indicate in question 24, how long ago they last had sex. The indication to this question required respondents to indicate whether it was in the past week, a month ago or a year ago.

Figure 27: How long ago did you last have sex?



Results showed that half of the respondents 91 (50%) had sex a month ago, followed by 51 (28%) that had sex a year ago and 40 (22%) that had sex in the past week (figure 27). The results could be an indication that sex was more regular on a monthly basis.

Of those who had sex in a month ago, 30% were males and 20% were females. With the other periods of last time of sex, male percentages were more than those of females by 2%.

The results of sex in a month ago indicated regularity amongst the 18 year olds who accounted for 15% and all others for percentages below 11%. Sex in a month ago amongst the grades was more regular amongst the grade 10 and 11 respondents with 20% each while the grade 9's accounted for 10%.

6.5.2 Risk Patterns of Sexual Engagement

The pattern of risk in terms of sexual engagement was determined by whether respondents continued to have sex, the frequency with which sex was done, the number of sexual partners and the use of condoms.

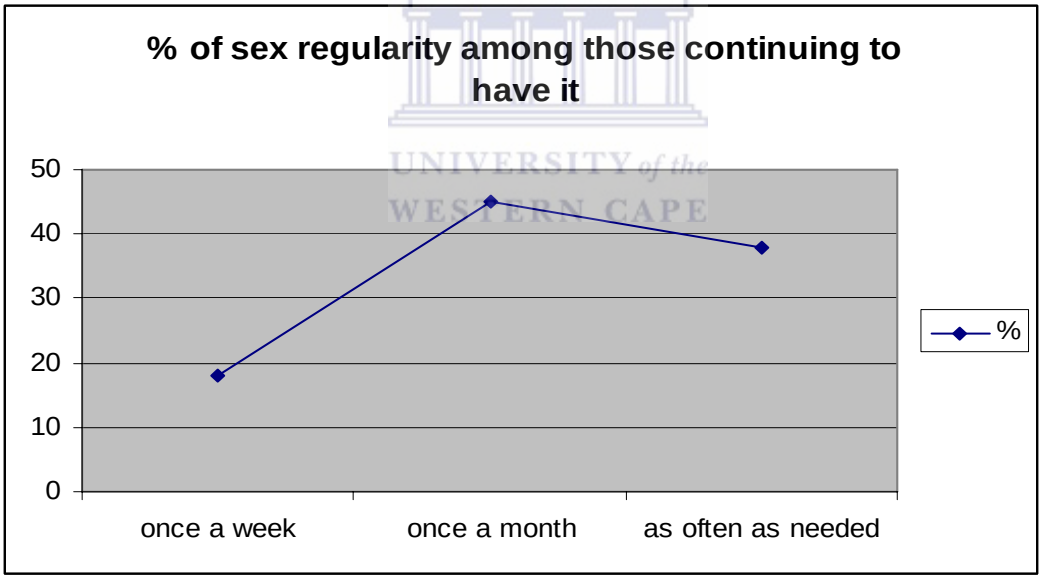
6.5.2.1 Continuation of Having Sex

With regards to the question of whether respondents continued having sex since the first time they had it, it emerged that the majority (67%) of respondents continued to have sex as opposed to 33% who no longer engaged in it.

When comparing between the age at first sex and whether they continued having sex, those who started having sex at the age of 15 continued having it more than other groups by 54%, followed by those who started it when they were between 10 and 15 years (34%) and those who started it when they were younger than 10 years (12%). This could mean that the older the age of respondents at first sex, the more likely they would continue having sex.

6.5.2.2 Frequency of Sex

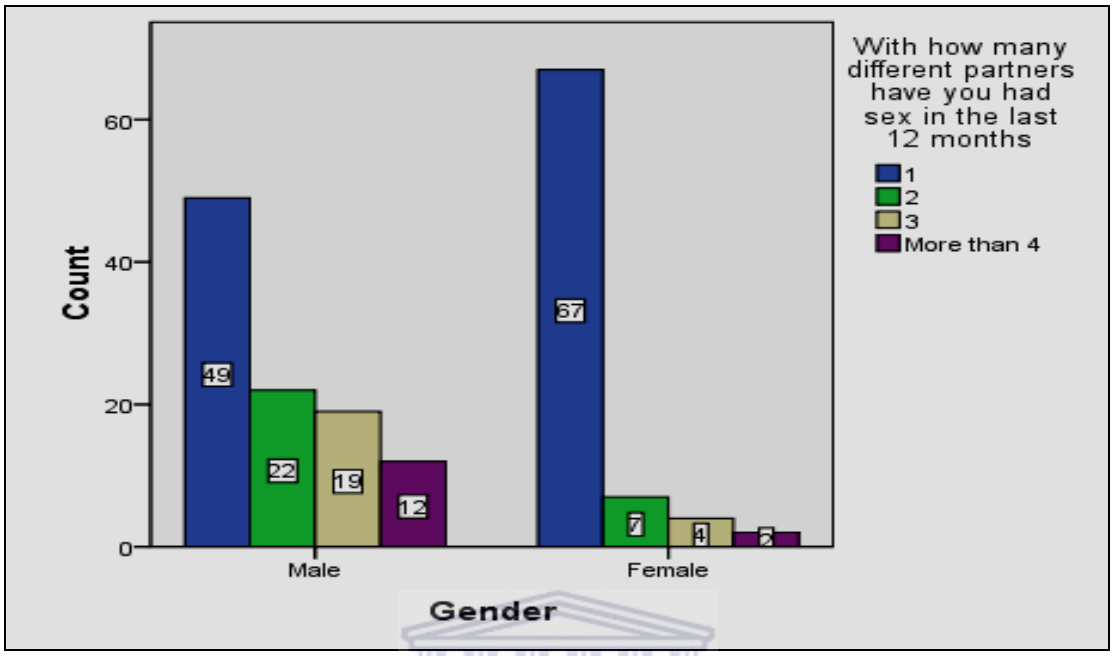
Figure 28: The regularity of sex among respondents continuing to have sex



Amongst those that continued to have sex, it was often done once per month (45%) or as often as needed (38%). It was indicated in lower percentages that sex was often done once a week (18%) figure 28. However, the regularity of once a week could be regarded as the minimum for the analysis considering that 38% had it as often as needed.

6.5.2.3 Number of Partners

Figure 29: Number of Partners by Gender



With regards to the number of partners (figure 29), the following results were reported:

- The majority of both male and females indicated that they had 1 partner 116 (64%);
- 29 (16%) reported having 2 partners and 12% of them were males and 2% were females;
- 23 (12%) reported having 3 partners and 10% of them were males and 2% were females;
- 14 (8%) reported having more than 4 partners and 7% of them were males and 1% were females.

From the results indicated above, it can be reported that a pattern of having more than one partner was seen more frequently amongst males than females.

6.5.2.4 Knowledge of Partner at Last Sex and Use of Prevention.

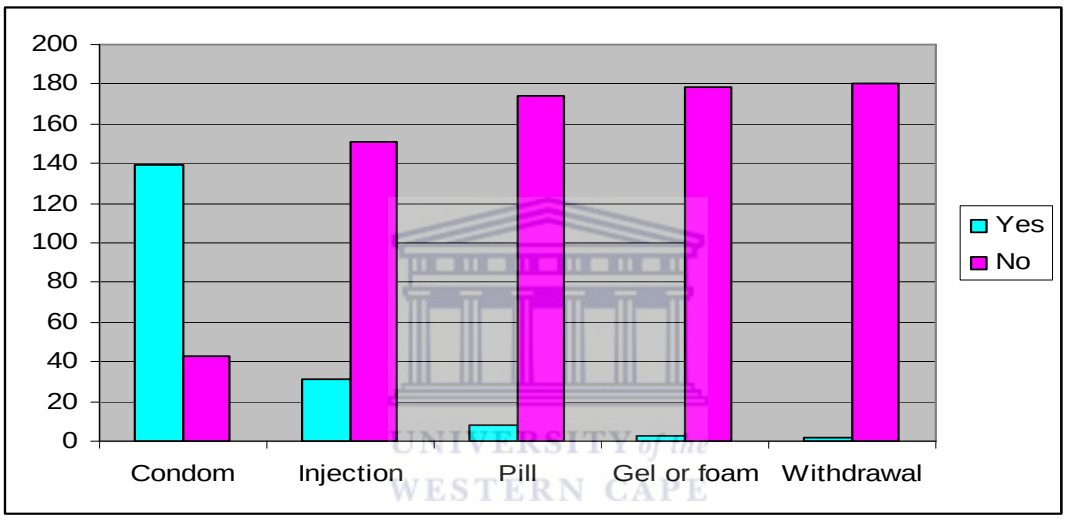
Cross-tabulations were performed from a total of 182 respondents who had sex to establish whether they knew their partners at last sex and whether they

used any form of protection for pregnancy or infections. Responses drawn from this total were divided between those who knew their partner and those who did not.

Among those that knew their partner, 109 (60%) of them used some form of protection as compared to 28 (15%) who did not use protection. Among those who did not know their partner, 38 (21%) used some form of protection as compared to 7 (4%) who did not.

6.5.2.5 Preferred Method of Prevention

Figure 30: Various Methods of Prevention as chosen by respondents



Results on whether a form of protection was used at last sex indicated that 81% of participants did use some form of protection whereas 19% did not. Figure 30 is an indication of the most preferred method of prevention at last sex. It should be noted that comparisons amongst these methods were only based on the total number of respondents' preferences of a prevention method and not on comparing methods of prevention against each other. The use of condoms emerged as a favourable method of prevention among respondents, followed by the use of injection. Within the use of condoms, analysis indicated that a total of 139 (76%) of both male and female respondents preferred the use of condoms.

Table 6: Gender * If yes what did you or your partner use: Condom Cross-tabulation

	If yes what did you or your partner use: Condom

		Yes	No	Total
Male	Count	75	27	102
	% within Gender	73.5%	26.5%	100.0%
Female	Count	64	16	80
	% within Gender	80.0%	20.0%	100.0%
Total	Count	139	43	182
	% within Gender	76.4%	23.6%	100.0%

6.5.2.6 Reasons for having sex by Age and Gender

Figure 31: Respondents' Reasons for Having Sex

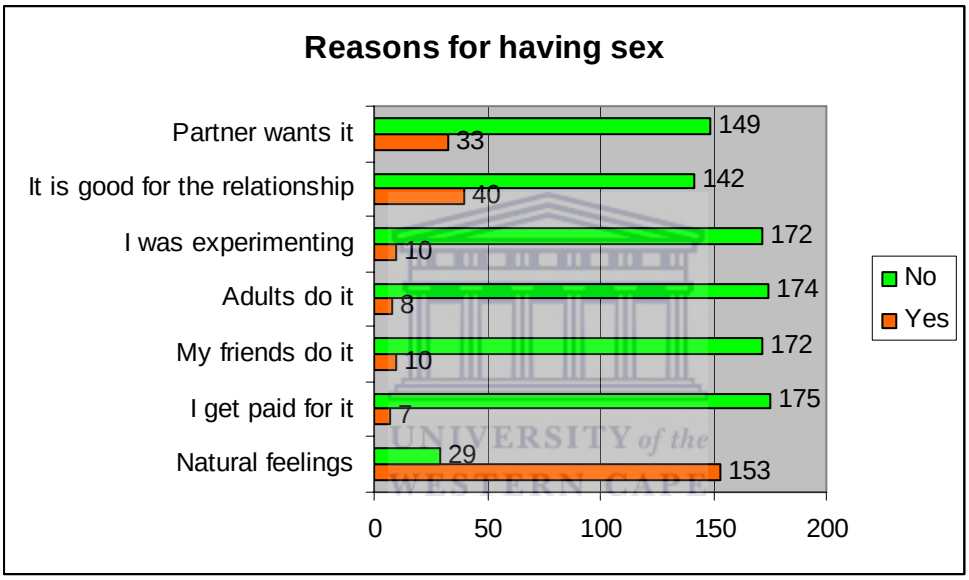


Figure 31 is an indication of respondents' reasons for having sex. The indication is only for respondents who had sex. The most compelling reason for having sex was because of natural feelings, followed by an indication that sex was good for the relationship and that the partner wanted it.

6.6 Knowledge and Sexual Behaviour

6.6.1 General basic knowledge of HIV/AIDS and ever had sex

Table 7: Chi-Square Tests General basic knowledge and ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.124[a]	1	.725
Likelihood Ratio	.124	1	.725

Linear-by-Linear Association	.124	1	.725
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 59.50.

Cross-tabulations on general basic knowledge and whether respondents ever had sex produced a chi-square statistic of 0.124 with 1 degree of freedom (table 7). The observed probability value is 0.725 and is well above the 0.05 or 5%, meaning that there is a 72.5% chance that there is no association between general basic knowledge and respondents having had sex. Therefore, the null hypothesis is accepted. This chi-square statistic is reliable as no cells had expected frequencies of less than 5.

6.6.2 Knowledge of HIV/AIDS transmission and ever had sex

Table 8: Chi-Square Tests Knowledge of HIV/AIDS transmission and have you ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.214[a]	1	.644
Likelihood Ratio	.215	1	.643
Linear-by-Linear Association	.213	1	.644
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 23.56.

Looking at the association between knowledge of HIV/AIDS transmission and ever had sex (table 8), a chi-square value of 0.214 with 1 degree of freedom. The given probability value is 0.644, a result indicating that there is 64.4% chance of null hypothesis being true. It can therefore be reported that there is no association between knowledge of HIV/AIDS prevention and respondents ever having sex. The analysis is also likely to be a reliable one as neither of the expected frequency criteria was violated.

6.6.3 Knowledge of HIV/AIDS prevention and ever had sex

Table 9: Chi-Square Tests of Knowledge of HIV/AIDS prevention and ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.044[a]	1	.833
Likelihood Ratio	.044	1	.833

Linear-by-Linear Association	.044	1	.834
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 49.12.

Table 9 provides results looking at the association between knowledge of HIV/AIDS prevention and respondents ever having sex. Results produced a chi-square value of 0.44 with 1 degree of freedom and observed probability value of 0.833. This indicates that there is an 83.3% chance of the null hypothesis being true and no evidence to reject it. We are therefore stating that it is likely that's there is no association between respondents' knowledge of HIV/AIDS prevention and the report on ever having had sex.

6.6.4 General basic knowledge of HIV/AIDS and continuing having sex

Table 10: Chi-Square Tests General Basic Knowledge and do you continue having sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.398[a]	1	.528
Likelihood Ratio	.398	1	.528
Linear-by-Linear Association	.396	1	.529
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 30.00.

Analysis was performed to determine whether there is an association between respondents' general basic knowledge of HIV/AIDS and their continuation to have sex (table 10). Chi-square statistic of 0.398 with 1 degree of freedom was produced. The observed probability value is 0.528, meaning that there is a 52.8% chance of the null hypothesis being true. It can be reported that there is no association between respondents' general basic knowledge of HIV/AIDS and their continuation to have sex. No cells have expected frequencies of less than 5, meaning that the chi-square is a reliable one.

6.6.5 Knowledge of HIV/AIDS transmission and continuing having sex

Table 11: Chi-Square Tests HIV/AIDS transmission and do you continue having sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.570[a]	1	.210

Likelihood Ratio	1.634	1	.201
Linear-by-Linear Association	1.561	1	.211
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.20.

Chi-square statistic of 1.57 for knowledge of HIV/AIDS transmission and continuation to have sex was produced with 1 degree of freedom. Probability value is observed at 0.21, indicating that there is a 21% chance of the null hypothesis being true. Thus, it can be reported that there is no association between respondents' knowledge of transmission and their continuity to have sex. The analysis is also reliable as no less than 5 frequencies were expected.

6.6.6 Knowledge of HIV/AIDS prevention and continue having sex

Table 12: Chi-Square Tests Knowledge of HIV/AIDS prevention and do you continue having sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.808[a]	1	.051
Likelihood Ratio	3.888	1	.049
Linear-by-Linear Association	3.788	1	.052
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 24.07.

Analysis was also conducted to determine the association between knowledge of prevention and continuity to have sex. The value of chi-square is 3.808 with 1 degree of freedom and an observed probability value of 0.051. This means that there is a 5% significant chance of the null hypothesis being true. However, because 5% was chosen as the significant level, the null hypothesis is rejected even though it is accepted that there is 5% chance of it being true. Thus, an alternative hypothesis is accepted meaning that there is an association between participants' knowledge of prevention and their continuation to have sex.

6.6.7 General basic knowledge and age at first sex

Table 13: Chi-Square Tests General basic knowledge and age at first sex

	Value	df	Asymp. Sig. (2-sided)

Pearson Chi-Square	.139[a]	2	.933
Likelihood Ratio	.139	2	.933
Linear-by-Linear Association	.000	1	1.000
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.50.

An analysis concerned with determining respondents' general basic knowledge and age at first sex, was conducted. Chi-square statistic of 0.139 was produced with 2 degrees of freedom and an observed probability of 0.933. The result is an indication that there is a 93.3% chance of the null hypothesis being true. The null hypothesis is therefore accepted, meaning that there is no association between general basic knowledge and age at first sex.

6.6.8 Knowledge of HIV/AIDS transmission and age at first sex

Table 14: Chi-Square Tests Knowledge of HIV/AIDS transmission and age at first sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.082[a]	2	.353
Likelihood Ratio	2.009	2	.366
Linear-by-Linear Association	.564	1	.452
N of Valid Cases	182		

a. 1 cell (16.7%) expected count less than 5. The minimum expected count is 3.46.

Table 14 illustrates results from analysing an association between knowledge of HIV/AIDS transmission and age at first sex. Chi-square statistic of 2.082 was produced with 2 degrees of freedom and a probability value of 0.353. This means that there is a 35.3% chance of the null hypothesis being true and it can be reported that there is no association between knowledge of HIV/AIDS transmission and respondents' age at first sex. The analysis is considered to be reliable and therefore accepted.

6.6.9 Knowledge of HIV/AIDS prevention and age at first sex

Table 15: Chi-Square Tests Knowledge of HIV/AIDS prevention and age at first sex

	Value	df	Asymp. Sig. (2-sided)

Pearson Chi-Square	.189[a]	2	.910
Likelihood Ratio	.191	2	.909
Linear-by-Linear Association	.063	1	.802
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.82.

Results in table 15 produced a chi-square statistic of 0.189 with 2 degrees of freedom and observed a probability value of 0.910. The null hypothesis is accepted as there is a 91.0% chance of it being true. No cells expected a less than 5 count and the analysis is reliable.

6.6.10 General basic knowledge of HIV/AIDS and number of partners

Table 16: Chi-Square Tests General basic knowledge and number of partners

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.278[a]	3	.351
Likelihood Ratio	3.318	3	.345
Linear-by-Linear Association	.052	1	.819
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.00.

No significant association was observed between general basic knowledge of HIV/AIDS and number of partners. The chance of the null hypothesis being true is 35.1% with 3 degrees of freedom and it is therefore accepted. The analysis is therefore reliable.

6.6.11 Knowledge of HIV/AIDS transmission and number of partners

Table 17: Chi-Square Tests HIV/AIDS transmission and number of partners

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.050[a]	3	.384
Likelihood Ratio	3.341	3	.342
Linear-by-Linear Association	.022	1	.882
N of Valid Cases	182		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 2.85.

Results indicate no significant association existing between knowledge of HIV/AIDS transmission and number of partners. There is a 38.4% chance of the null hypothesis being true and can therefore not be rejected.

6.6.12 Knowledge of HIV/AIDS prevention and number of partners

Table 18: Chi-Square Tests HIV/AIDS prevention and number of partners

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.647[a]	3	.649
Likelihood Ratio	1.618	3	.655
Linear-by-Linear Association	.227	1	.633
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.62.

There is no significant association observed within the knowledge of prevention and number of partners. There is a 64.9% chance of the null hypothesis being true.

*6.6.*13 Respondents' *knowledge of their HIV/AIDS status and ever having sex*

Table 19: Chi-Square Tests Knowledge of HIV/AIDS status of self and ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.862[a]	1	.353
Likelihood Ratio	.871	1	.351
Linear-by-Linear Association	.859	1	.354
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 28.35.

Results indicate no significant association between respondents' knowledge of their HIV/AIDS status and ever having sex. There is a 35.3% chance of the null hypothesis being true.

6.7 Attitudes and Sexual Behaviour

An analysis comparing attitudes of respondents towards people infected with HIV/AIDS, their perceived risk of infection and sexual behaviour was conducted. The following results were obtained:

6.7.1 Respondents' knowledge of people who revealed their HIV/AIDS statuses and sexual behaviour:

- There is no significant association between knowledge of people who revealed their statuses and respondents' ever having sex. The null hypothesis has a 36.0% chance of being true;
- No significant association exists between knowledge of people who revealed their HIV/AIDS statuses and number of partners. The null hypothesis has a 31.9% chance of being true;
- No significant association exists between respondents' knowledge of people who revealed their HIV/AIDS statuses and the frequency of having sex. There is a 23.5% chance of the null hypothesis being true.

6.7.2 Respondents' perceived risk of infection and sexual behaviour:

- There is a significant association between respondents' perceived risk of infection and the frequency of having sex. Observed probability is 0.005 and the alternative hypothesis is therefore accepted;
- There is no association between respondents' perceived risk of infection and number of partners. The null hypothesis has a 12.5% chance of being true;
- There is no association between respondents' perceived risk of infection and ever having sex. The null hypothesis has a 10.8% chance of not being rejected

6.8 Qualitative Findings

Qualitative data were collected within the questionnaire using open-ended questions and section 4 of the questionnaire was dedicated for this purpose. Questions 34 to 37 focused on exploring problems experienced by participants when seeking help and/or information in various social settings in the community. Questions particularly explored problems experienced from parents, clinics (nurses), schools (teachers) and peer groups (other teenagers). Questions 38 to 41 explored participants' suggestions on what role can be played by each of those people from whom problems are experienced towards the prevention of risky sexual behaviours among teenagers. In the discussion that follows I first summarize the findings into

themes and sub-themes (where relevant) with examples of quotes of participants that best summarizes their experiences. This is followed by a brief explanatory discussion.

6.8.1 Problems Experienced by Teenagers when seeking Information or Help Related to HIV/AIDS and Sex

6.8.1.1 Problems experienced at clinics

Table 20: Thematic breakdown of problems at clinic

Theme	Sub-theme and/or d Quotes that summarises experiences.	# of responses out of 303
Moralising behaviour –of nurses based on own beliefs/opinion of sex	"they tell us we are too young to know about sex" "nurses say sex is for adults"	250
Attitude/Behaviour of nurses	**Verbal abuse** "Nurses shout at us", "nurses are cheeky and I am scared they will shout at me"	233
	Unapproachable attitude "Nurses are not approachable, the people that work at clinics are not friendly and are not open for us to talk to them", nurses don't care"	169
	Discrimination "sometimes they think we have HIV/AIDS, nurses already think we do sex"	104
	Belittling attitude "nurses laugh at our questions, you see nurses laughing and calling others to come hear you and nurses laugh at our questions"	157
Unfriendly environment	**Waiting in long queues** "they don't help us in time so you get bored waiting for long and people watching you, I wait for a long time in the clinic and I don't like standing in line"	175
	Clinics do not protect confidentiality "sometimes we go to the clinic then we meet with our parents there, then we end up not getting what we wanted, you get afraid to make tests at the clinic" "Sometimes you are seen by a neighbour or relative and the next thing your parents know you were at the clinic"	123
	Lack of assistance and attention "nurses are not willing to help teenagers" and they say they are busy and have time for other patients"	291
	Bad treatment "nurses give you injection, pill or condom when you just need information"	98

A thematic breakdown of problems experienced at clinics (table 20) indicated nurses' beliefs and opinions, attitudes and behaviour and unfriendly environment as leading problems experienced by teenagers when wanting information or help at clinics. They thus feel scared and shy to approach the nurses or clinics for information.

a) Moralizing behaviour based on believes and opinions of nurses.

A very strong theme that emerged in relation to the question on experiences of community clinics was the moralizing behaviour of nurses. Learners perceptions were that this behaviour was based on own believes and opinions of nurses and it scared them off to approach the clinics for information on sex. Extracts such as "they tell us we are too young for sex", "nurses say sex is for adults" were indicated.

b) Attitudes and behaviour

With regards to attitudes and behaviour theme, verbal abuse mainly in a form of shouting was indicated as the commonly experienced problem by the majority (233) of teenagers. Phrases such as "nurses shout at us" and "nurses are cheeky and I am scared they will shout at me" emerged mostly as responses among participants. A significant number of participants (169) indicated that nurses are not accessible "not approachable and are also not open for us to talk to them" and therefore teenagers become afraid and shy to ask for help. Other sub-themes under the attitudes and behaviour of nurses were the discrimination and belittling attitudes of nurses towards teenagers at clinics. Participants expressed that "nurses already think you have sex and "you see nurses laughing and calling others to come hear you, and laugh at your questions" as some of their mostly experienced forms of discrimination and belittling.

c) Unfriendly environment

The theme of unfriendly environment characterised with sub-themes of waiting in long queues, unprotected confidentiality, lack of assistance and bad treatment from nurses formed part of the experienced problems. It was expressed by teenagers that they wait in long queues without being helped

and this lead to being seen by other people including parents and or family members. Phrases such as “they don’t help us in time so you get bored waiting for long and people watching you; the next thing your parents know that you were at the clinic” emerged. Moreover, teenagers are also afraid to take tests and also experience the unwillingness of nurses to help them. Exact responses included “nurses passes you”, and “nurses are not interested in teenagers and will tell you they have patients to attend”. On the contrary, participants reported that they would **be given injections or pills without any information.** Such experiences may leave information seeking teenagers feeling afraid, exposed, unprotected, dismissed and as a result give up on gaining important information of a life-time.

Similar findings by Wood, Maepa and Jewkes (undated) in the Northern Province in South Africa confirm that one of the most important concerns of adolescents when visiting a public health clinic for contraceptives was the attitudes of nursing staff. Teenagers reported “verbal harassment by nurses scolding”, asking “funny” questions and being rude, short tempered and arrogant. Nurses perceived that moral guidance is part of their roles. The study also supports the finding that adolescents regard the clinic setting as problematic especially when sharing a waiting area with elders.

8.1.2 Problems experienced from parents

Table 21: Thematic breakdown of problems from parents

Theme	Sub-theme and Quote that summarises experiences.	# of responses out of 303
Communication and relationship with parents	**Lack of attention, time and willingness to listen** “parents don’t listen, they say it is not the right time, my mother was busy drinking alcohol” **Lack of confidence to speak about sex** “our parents say they have no time for such things, parents swear they will never speak to us about sex”	300 107
Parents attitudes and behaviour	**Verbal abuse** “parents shout and want to beat you” ” Some parents are strict so you get scared to ask, parents get angry and make you feel guilty, parents say teenagers hold no respect for them **Physical and Emotional abuse** “teens don’t feel free as parents harass and beat you, some parents are moody, so	264 169

	we are afraid"	
Parents' lack of information	**Misinformed** "parents don't tell right answers" **Need information** "parents need information about sex themselves, parents don't have such information, some parents don't know much and cannot help"	157 270
Assumptions and fears about sex	**Fear of unknown** "parents always think pregnancy and don't want to talk about sex, Parents think you will go and have sex, parents think you already have sex"	298

With regards to problems experienced from parents, the themes of communication and relationship with parents, parents' attitudes and behaviour, parents' lack of information and assumptions about sex were identified (table 21).

a) Communication and relationship with parents

Communication and relationship with parents have been indicated as a major barrier or problem between parents and teenagers in this study. A strong sub-theme that emerged in this regard is lack of attention, time and willingness to listen to children's needs. 300 responses fit into this theme. Also parents do not encourage communication and information sharing about sex, as one participant summarizes "they will never speak to us about sex".

b) Parents' attitudes and behaviour

Sub-themes of verbal, physical and emotional abuse were identified as problems linked to the attitudes and behaviour of parents. The attitudes and behaviour of parents seemed to be a very serious issue for teenagers, making it difficult for them to seek help within their families. 264 responses fit to this sub-theme. Responses such as "parents shout and want to beat you", and that "some parents fight teenagers" summarize the overall perceptions. These behaviours by parents around topics of sex and HIV/AIDS were viewed as rather harsh and leave teenagers feeling afraid to open up discussions on the topic.

c) Parents lack information

According to participants, it is not just that parents do not want to talk, but they might lack information (270) and skills to talk about sex. Learners also thought that parents are misinformed (157) on HIV/AIDS themselves.

d) Fears and Assumptions about sex information to adolescents

Participants experienced that parents have assumptions about sex which are imposed and therefore forming barriers to giving and getting information. Parents "always think pregnancy" the moment they ask them questions or assume that "we already have sex" or "think you will go have sex". Therefore parents are reluctant to share sex information.

Beliefs about the role of the family versus health professional and the state have been addressed in several studies (Nathanson 1991, Kreinen and Smith 1999, Senderowitz 1999). A study by Mturi (2001) in Lesotho highlights the problem of communications about sex between parents and adolescents. The study supports the experiences of participants in my study that parents are either shy to discuss sex related matter or they think the discussion will encourage sexual activities. Some parents blame tradition that these issues are not supposed to be discussed. Rio (2006) acknowledges that cultural practices have strong influences that maintain talking about sex or contraceptives as taboo in many African countries. Khan (2006) also addressed controversies and fears of parents with regards to the provision of proper information on issues of sexuality. A study by Wodi (2005) note the cultural constraints associated with the prevention of HIV/AIDS. In his study, youth respondents had never discussed HIV/AIDS with their parents or guardians.

6.8.1.3 Problems experienced with teachers regarding sex and HIV education.

Table 22: Thematic breakdown of problems with teachers

Theme	Sub-theme and Quote that summarises experiences.	# of responses out of 303

Attitudes and misbehaviour by teachers	**Judgemental attitude by teachers** "Some teachers say that we know nothing about school work but jump to adult things" **Sex with learners** "Other teachers take advantage and have sex with teenagers; teenagers are seduced by educators in many ways". "Teachers end up sleeping with them, teachers propose to them"	16 98
Time constraints	**Lack of time** "Teachers lack time to talk about HIV/AIDS" **Laisser-faire** "Some teachers say they don't teach LO, you should go to LO teacher, they tell us we must find information from our parents, teachers tell us to go to clinic"	79 101

Among the problems experienced from teachers, two themes, i.e. the attitudes and behaviour of teachers and the time constraints were identified. It needs to be noted that despite the identified themes, a significant number of **participants (112) felt and expressed that teachers are the reachable sources of information and phrases such as:**

"No problem, teachers are supportive, they just answer you because they know that teens get into these things and need help, and teachers are most helpful" were some of the responses given.

a) Attitudes and misbehaviour by teachers

With regards to the problems experienced from teachers under this theme, sub-themes of sexual misbehaviour, judgement and teachers taking opportunity were identified. Participants indicated that when seeking information from teachers, other "teachers take advantage and end up sleeping with learners". Thus, when teenagers seek information, it is viewed by other teachers as an opportunity to have sex with learners. Other learners felt that they are being judged by teachers and therefore making it difficult for them to seek information. Learners expressed that they are being told that "they know nothing about their school work and jump to adult things" or that the treatment from teachers start being different towards a learner that sought information.

b) Time constraints

Participants are of the opinion that even though teachers may be willing to help them when seeking information, they normally do not have time within their schedules to accommodate questions from learners. Other teachers who, are perceived to have time, opt to be not involved with the subject and refer learners to Life Orientation (LO) or are referred to their parents or clinics for information".

Studies indicate that teachers and other professionals are reluctant to provide unmarried or childless young people, especially girls, with sexual knowledge and/or contraceptives (Murray, Stewart & Rosen, 2000). McCall & McKay (2004) indicate that even in a developed country like Canada the sexual health education to the youth in schools are inadequate. Schools do not provide adequate instructional time and teachers shy away from several key issues. The need for a coordinated system between schools and health systems is strongly recommended in these studies.

6.8.1.4 Problems experienced from peers

Table 23: Thematic breakdown of problems from teenagers

Theme	Sub-theme and Quote that summarises experiences.	# of responses out of 303
Lack of confidentiality respect and trust	**Inability to keep secret** "they tell everyone about your secret and expose your privacy, they never keep your problem to them and your information is not safe". **Disrespect and name calling** "they laugh at you and they say you are a stupid virgin" "others gossip about you"	184 156
Lack of information and Misleading information	**Misinformed** "they give you wrong information, they don't have a clue, they lie to you" **Promoting teen sex:** "other teens advise you to try it as it is fun, they tell you to go have it and you'll feel good, they tell you that you are going to get sick if you don't have it, they give bad ideas and pretend to have information and they make you have sex	102 298
Engaged in own issues.	"they tell you what happened to them instead"	118

Problems from other teenagers were expressed as mainly being around themes of lack of confidentiality, lack of information and misleading and engagement in own issues. It may seem that learners lack trust and are reluctant to obtain information from other teenagers due to the following reasons.

a) Lack of confidentiality, respect and trust

With regards to this theme, participants felt that once they seek information or share their problems with other teenagers, they become exposed and their information known to everyone, they are not respected and that they lack trust towards others. The problem with other teenagers was that they "do not keep secret, they tell everyone about your problem and your information is not safe". The other problem experienced within this theme is that of not being respected and being called names by other teenagers. Of particular, participants said other teenagers say "you are a stupid virgin or they laugh at you".

b) Lack of information and misleading information

Participants indicated that other adolescents are not good resources of information because they lack information or "give you wrong information". Quotes like: "they lie to you…" and "they have no clue…" were given. Moreover, participants stated that other teenagers promote sexual behaviour by telling them to "try sex, that sex is fun, you'll feel good after having it and that you will get sick if you don't have it".

c) Judgement

A significant number of participants (118) reported that other teenagers would talk about themselves when others seek information or help. This is done through telling what happened to them instead and as a result identified as a form of judgement.

The providing of misleading information among teenagers is also reported by Ajuwon et al. (2006) who indicate that adolescents harbour misconceptions around issues of sexual engagements. In terms of leading others into having

sex, Varga (1999) note the role of same sex peer pressure in creating pressure to initiate sex. In this study, young people indicated having sex because their friends do it.

6.8.2 Suggestions on roles towards preventing risky sexual behaviours

6.8.2.1 Suggestions on roles of parents

Table 24: Thematic breakdown of parents' roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303
Communication and accessibility	**Verbal communication** "talk to us about sex, be open and love them enough to talk about sex, encourage their children to have one partner, parents have to sit down with their children and talk about these issues"	300
	Be friendly "parents should talk to their children and stop being rude, they should at least try to talk to their children about the risks of sexual behaviour and talk nicely without shouting, parents should not be strict and talk to their children so that they become open to them"	297
	Transparency "talk openly and answer questions openly, parents have to be fair and honest to tell us about sex"	245
Responsibility	**Give advise** "parents should advice teenagers about sexual behaviour and its consequences, every parent must protect his child because we have high rate of teenage pregnancy in the country"	280
	Teach "teach and show kids how to protect themselves and what problems they will face"	291
	Guide "parents must be free to talk to us about HIV/AIDS and be good examples"	187
	Intervene "stop teenagers from going to clubs, stop their children from going around at night, they have to stop children from drinking alcohol, selling their bodies and working at night"	166

On enquiring about what can be done by parents to prevent risky sexual behaviour among teenagers, communication and accessibility and responsibility emerged as themes from the suggested roles. Participants gave the following responses within themes.

a) Communication

Within the theme of communication and accessibility, participants felt that parents need to engage in verbal communication with their children. Phrases such as “talk to us about sex” were strongly indicated by many participants.

Participants also indicated that parents should be more accessible to their children through being friendly and transparent. As indicated in their responses, there were indications that parents should “stop being rude, talk nicely and be open” to teenagers.

b) Responsibility

Within the theme of responsibility, roles such as giving advice, teaching, guiding and intervening were allocated to parents by participants. More specifically, participants felt that parents should advice teenagers, teach and show kids how to protect themselves and what problems they will face and be good examples. Other roles such as stopping teenagers from going to clubs and stopping children from drinking alcohol, selling their bodies and working at night were given by participants.

6.8.2.2 Suggestions on roles of teachers

Table 25: Thematic breakdown of teachers’ roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303
Give information about HIV/AIDS and sexuality	**Teach** “teach the learners about the consequences of doing sex, teach teens about HIV/AIDS and give them knowledge, teach about this problem and stop taking advantage”	287
	Discuss “they should talk about sex and encourage teenagers to practice safe sex or abstain, have periods where life is discussed, have periods where teachers teach about sexual behaviour”	284
Reach out	**Give advise** “advise and help teenagers about unprotected sex and pregnancy”, they should all be involved in talking to us”	179
	Listen “give children a chance to reveal what they know or think”	168

Take action	**Implement ways of distributing information** "open groups of people who can motivate teenagers, guide learners about risky sexual behaviours, give more lesson or HIV workshops, do some activities and programmes at school like Lovelife so that many teenagers may be aware, give special class for sex and develop HIV/AIDS debating groups at school"	294

The roles to be played by teachers were divided into themes of giving information about HIV/AIDS and sexuality, reaching out and taking action.

a) Give information about HIV/AIDS and sexuality

The role of giving information was highlighted by a lot of participants. It was indicated that teachers should actively teach learners and give them knowledge about the consequences of doing sex, that teachers should hold discussions to talk about sex and encourage teenagers to practice safe sex.

b) Reach out

This theme was identified as roles of teachers that could be exercised through giving advice and listening. Participants felt that teachers should advise teenagers on issues of unprotected sex and pregnancy. It was also indicated that the role of listening should be enforced through giving teenagers a chance to also share what they know about the topic under discussion.

c) Take action

Participants felt that teachers need to take action as a role towards prevention of risky sexual behaviour among teenagers. Within this theme, ways of distributing information were identified as an active role that can be played. Phrases indicating that teachers should open focus/debating groups, guide learners, give more lessons and workshops were identified as ways in which teachers can be involved.

6.8.2.3 Suggestions on roles of nurses

Table 26: Thematic breakdown of nurses' roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303

Be accessible	**Good treatment** "give nice services and advise that condoms are not 100% safe, "respect teenagers, be friendly and treat them with respect, allow teenagers to speak to them and stop being cheeky, stop shouting at us"	299
	Be supportive "encourage teens to use condoms if they think they are old enough to have sex, get more closer to teenagers and talk to them, always have time for teenagers when they are at the clinic"	281
Strategies	**Plan** "increase clinics in the community because one clinic is not enough, which is why nurses don't have time for us, get a chance to visit schools and tell learners about this information, counsel during weekends and teach more"	204
	Make time and give privacy "allocate special time for teenagers at the clinic, open a section at the clinic and make extra hour for teenagers"	274
	Network "nurses must go to schools and advise teenagers and have workshops at schools"	276
Give information	**Communicate** "provide condoms and pamphlets about HIV/AIDS, tell stories of sex in the clinic"	256
	Advise "tell teenagers how important it is to use condoms or abstain, make teenagers aware of the dangers of risky sexual behaviour, advise teenagers on how to be safe from getting HIV/AIDS and unwanted pregnancy"	197

Among the roles allocated to nurses, the themes of be accessible, strategies and give information emerged and are discussed below.

a) Be accessible

Participants felt that nurses should give teenagers good treatment and become supportive as their role towards preventing risky sexual behaviours among teenagers. The phrases in terms of good treatment "give nice services…., respect teenagers, allow teenagers to speak and stop shouting at us" were indicated. It was also felt by participants that nurses should be supportive towards learners through encouraging the use of condoms, by getting more closer to teenagers and having time for teenagers at the clinic.

b) Strategies

Within the theme of strategising, participants indicated that the role that can be played by nurses would be through planning around issues of teenagers, making time and giving privacy and networking. With regards to planning,

participants were of view that clinics should be increased, that nurses should visit schools and counsel during weekends. Participants also indicated that nurses should allocate special time for teenagers at the clinic and that they should go to school and hold workshops.

c) Give information

Sub-themes of communicating and advising were identified within the theme of giving information. Provision of condoms and pamphlets about HIV/AIDS was one phrase that indicated participants' suggestions on how information could be distributed. It was also indicated by participants that nurses should play a role of telling teens about the importance of using condoms or abstaining, making teens aware of the dangers of risky sexual behaviours and also give advice on safety from getting HIV/AIDS and unwanted pregnancies.

6.8.2.4 Suggestions on roles of teenagers

Table 27: Thematic breakdown of teenagers' roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303
Take responsibility	**Protection and taking a stance** "teenagers should abstain or have protected sex, we teenagers must take care of ourselves, use condoms and not sleep around, teenagers must protect themselves against HIV/AIDS, don't listen to friends and know when to say NO, stop having many sexual partners, have safe sex and go to clinic to know their status, stay away from alcohol because after drinking, they sleep around"	289
Communicate	**Verbal communication** "always talk about it, always advise each other and talk about the dangers of having unprotected sex" **Listen and respect** "trust each other and listen, talk to each other about their problems, teenagers need to respect each other and the choices they make"	205 198
Get involved	**Offer help** "give each others the right advise, we should work together as teenagers and encourage each other about positive things in life" **Take initiatives** "have teenager groups and talks about sexual behaviour and encourage each other, open youth group where they will get and give information, try to keep themselves busy so that they don't think about sex, open a free club like youth alive at school, get involved in support groups and express themselves to overcome peer pressure"	216 293

In response to the question of what role can be played by other teenagers towards preventing risky sexual behaviours among teenagers, the following themes and sub-themes emerged.

a) Take responsibility

Participants indicated that teenagers should take responsibility of their lives through protecting themselves and taking a stance. Phrases such as "teenagers should abstain or have protected sex, use condoms and not sleep around, don't listen to friends and know when to say no" were suggested strongly as ways of protection and taking a stance. Participants also suggested that teenagers should also protect themselves by not having many sexual partners and staying away from alcohol.

b) Communicate

The theme of communication was identified and went with sub-themes of verbal communication, listening and respect. It was suggested that teenagers should play a role of verbal communication through always talking about HIV/AIDS and the dangers of unprotected sex with other teenagers. As a way of communication, it was felt that teenagers should trust each other and respect one another and the choices each other make.

c) Get involved

Getting involved was identified as a theme and under it were sub-themes of offering help and taking initiatives as roles that can be played by teenagers towards preventing risky sexual behaviours among teenagers. Participants indicated that teenagers should give each other right advices and have positive influence in each other's lives by encouraging positive things. It was also strongly suggested that teenagers should also take initiatives by getting involved or having among other things, teenage support or youth groups where they could help each other and get support to overcome peer pressure.

6.8.3 Summary

Participants generally had poor knowledge levels based on general basic knowledge, transmission and prevention subcategories. The poor knowledge levels are above 90%, indicating limited knowledge on factual information about what HIV/AIDS is, how it is contracted and how it can be prevented. The poor knowledge varied considerably by gender, age and school grade and it is important to note those variations.

Information on the pandemic was easily obtained via various sources including talking with partners about it, which was an indication that the poor knowledge problem could be attributed to individual interpretation and how well the information was received and the correct understanding of it.

The majority of participants neither knew their statuses (77%) or that of their partners (84%) and fewer participants thought their partners were having other relationships. Over half of participants (54%) did not think they could be infected with HIV/AIDS but did think that their family members could be affected by the pandemic. There was a generally positive attitude towards people currently known to be infected and those who may be infected in future. This was indicated by participants' indication that they accepted and would in the future accept those who may be known to have HIV/AIDS. Most participants indicated that they had sex, and those continuing to have it after the first time had it with more than 1 partner. The average sex debut for participants was 15 years and the use of condoms at first sex and continuation thereof was popular amongst the participants. Participants indicated natural feelings as the most compelling reason for having sex.

Numerous indications on the problems experienced from parents, teachers, nurses and other teenagers were presented together with roles that can be played by these individuals towards reducing risky sexual behaviours among teenagers.

CHAPTER 7: DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The goal of this study was to quantitatively explore the knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in a rural Free State town, and as well as to qualitatively explore challenges experienced by learners when seeking information and their suggestions on intervention strategies.

The objectives of the survey were:

- To explore the knowledge levels, attitudes and sexual practices of high school learners at a selected rural town;
- To establish whether there is a difference in knowledge levels and sexual behaviour pattern of learners according to age at first sex;
- To establish whether there is an association between knowledge levels and sexual behaviours;
- To explore participants' perceptions about the information resources and what their suggestions are on prevention strategies.

The Null Hypotheses were:

- *There is no association between knowledge levels of learners and their sexual behaviours in terms of ever having sex and continuing to have sex;*
- *There is no association between knowledge and age at first sex;*
- *There is no association between perceived risk of infection and number of partners;*
- *There is no association between perceived risk of infection and frequency of sex.*

This chapter focuses on discussing the findings of the study based on the study objectives and literature. Discussion of the quantitative findings is structured according to the research objectives related to knowledge, attitudes

and sexual behaviour of learners. The qualitative findings of the open questions are presented according to the identified themes. Conclusions on the findings are also presented followed by the recommendations.

7.2 Summary of findings and literature relevance

7.2.1 Levels of knowledge, sexual practices and attitudes towards HIV positive people

An overall 64% of poor **knowledge** level of HIV/AIDS was found. The poor knowledge was based on general basic knowledge of HIV/AIDS (51%), transmission (81%) and prevention (59%) of the pandemic.

The poor knowledge varies by gender, age and grade but the variations are worth noting:

- Females generally had poorer basic knowledge of HIV/AIDS and transmission than males;
- More males than females had poor knowledge of prevention;
- It is important to note that with regards to age, even though respondents' knowledge was poor, the 18 year olds seemed to have more basic knowledge of HIV/AIDS and transmission than other age groups;
- However, the 18 year olds scored the lowest amongst other age groups in terms of good knowledge of prevention;
- Grade 11 learners were more knowledgeable on prevention of HIV/AIDS than other grades.

The findings differ significantly with those of the Free State youth survey (www.yry.ac.za) in which participants were found to be generally well informed with regards to knowledge of HIV/AIDS. The population in the Youth Survey were youth from selected towns (both rural and urban) of Free State. Thus, this could mean that conflicting results emanated from this study. The study of Pharaoh (2004) also contradicted my study as it found that participants were knowledgeable about transmission and lacked sufficient

knowledge about prevention, whereas this study found HIV/AIDS related knowledge to be poor on both transmission and prevention.

There was generally a positive **attitude** among the respondents towards people known to be infected and those who may be known in the future. They indicated that they accepted or would accept such people. Current and future avoidance of such people was mainly attributed to not knowing how to treat or being afraid of HIV/AIDS infected people. Only a few (2% on average) indicated that they avoid or would avoid people known to be infected because of not wanting to be associated with them. Jaiswal et al. (2005) observed a significant change in attitudes, where high school student reported that they would allow HIV positive people inside their house.

Respondents thought that HIV/AIDS could affect other people but they did not associate themselves with the risk of infection. This was proven by the finding that most respondents did not think they can be infected with HIV/AIDS but did think that their family members can be affected by it. The Reproductive Health Research Unit (2003) found that 62% of HIV infected and 73% of HIV negative South African youth who participated in a national survey thought that they were at little or no risk of contracting HIV. This study raised a concern about the underestimation of risk observed amongst the youth.

About 81% of respondents did not know their HIV status and the statuses of their partners. Inferences on this fact cannot be made and would need further exploration on how important this issue is to them. However, it is worth noting that Ntozi and Kirunga (1997) found in their study that 12% of respondents did not want to know their statuses because knowing will worry them more since the disease is not curable.

In terms of **sexual behaviour**, more respondents (60%) have had sex and continued to have it in higher percentages. The continuation of having sex was especially observed to be more likely among those whose sexual debut was at the age of 15. Males were more likely to have had sex at a younger age and continued having it more frequently with more than one partner than

females. Peltzer et al. (2005) and Pettifor et al. (2004) also observed similar results were initiation of sex was at an early age especially among male participants.

The majority of respondents seem to engage in safe sex in terms of the following indicators:

- Majority of those that continued having sex (64%) had one partner although special cognisance should be given to 16% of males who had at least two partners;
- Most respondents (76%) preferred the use of condoms as a form of protection when having sex and it was also used by most respondents at first sex. The results also indicated that 81% also used condoms at last sex. A study of Peltzer et al. (2005) indicates that condom use at first sex was indicated in high percentages by respondents, although 56% lower use of condoms at last sex was also reported;
- In most cases, the partners were known by those that continued to have sex.

7.2.2 Associations between Variables

Hypothesis: There is no association between knowledge levels of learner and their sexual behaviours in terms of ever having sex and continuing to have sex.

With regards to association between knowledge levels and respondents' sexual behaviour, the null hypothesis has been confirmed at the 95% confidence level. Findings indicated that respondents' knowledge levels of HIV/AIDS have no association with their decisions of having sex and continuing to have it. This could mean that what and how much they know do not affect or have an influence on their sexual behaviour.

Generally, this study found that knowledge with regards to HIV/AIDS among learners is poor, change in sexual behaviour is weak and the continuation of

engaging in sexual activities is rife. Thus, it is a poor knowledge versus weak change in behaviour pattern.

Other studies found that knowledge levels of young people were higher or sufficient but change in risky sexual behaviours was weak (Maswanya et al. (1999), James et al. (2004). These studies reported high levels of knowledge but weak correlation with behaviour change.

Hypothesis: There is no association between knowledge and age at first sex

With regard to the association between knowledge and age at first sex, the study found that male respondents initiated sex earlier than females. The null hypothesis has been confirmed at the 95% confidence level. No association was found between knowledge of HIV/AIDS and age at first sex

Hypothesis: There is no association between perceived risk of infection and the number of partners.

Perceived risk of infection was found to be not associated with the number of partners and the decision to have unprotected sex and the hypothesis has been confirmed at a 95% confidence level. This could imply that participants (especially male participants) thought that the number of partners one has, could not place them at risk of getting infected. Tefera (2004) found that over half of respondents (56.3%) who practiced unsafe sex did not perceive themselves to be at risk of HIV infection. Wodi (2005) also found that over half of youth in his study felt little threat from HIV/AIDS.

Hypothesis: There is no association between perceived risk of infection and frequency of sex

The hypothesis has been rejected at the 95% confidence level.
The analysis indicated that the frequency of having sex was associated with perceived risk of infection among the respondents. This could again mean

that respondents perceived that the possible danger of infection could result from how frequently sex is performed.

7.2.3 Participants experiences when seeking information or help and their suggestions on prevention of risky sexual behaviours

Qualitative data collection was aimed to carry out the objective of exploring problems experienced by participants and their suggestions towards preventing risky sexual behaviour among teenagers. Data were collected through the use of open-ended questions within the questionnaire. The problems were explored by enquiring what is experienced by participants when seeking information from parents, nurses, teachers and other teenagers. Subsequently, exploration of suggestions was based on enquiring what roles can be played by such people from whom problems are experienced towards the preventing sexual behaviour among teenagers. The themes that transpired from the analysis enable the following discussion on experiences of learners and their suggestions.

7.2.3.1 Problems experienced by teenagers when seeking information

The following themes emerged regarding the problems experienced by learners when seeking information or help around issues of HIV/AIDS and sex.

Problems with nurses

Problems experienced at clinics were mostly related to the behaviour of nurses. These include moralising behaviour, belittling and unapproachable attitudes of nurses as well as the experience of verbal abuse and discrimination. Clinics were viewed as unfriendly environments with no protection of confidentiality, bad treatment and lack of assistance. Similar findings by Wood et al. (undated) in the Northern Province in South Africa confirms that one of the most important concerns of adolescents when visiting a public health clinic for contraceptives was the attitudes of nursing staff.

Problems with parents

Communication, attitudes and accessibility of parents regarding the discussion of sex and HIV/AIDS were major problems experienced by teenagers. Participants experienced lack of attention, time and willingness of parents to listen to them. Participants also indicated that parents are not comfortable with discussing such topics and thus choose not to entertain them. According to participants, parents are strict and get angry towards their children in this regard. Verbal, physical and emotional abuse seemed to be more prominent among parents towards their children. There was also lack of confidence and fears among parents to speak about sex and HIV/AIDS.

Several studies support findings of my study regarding the role of parents in providing information to teenagers. (Nathanson 1991, Kreinen and Smith 1999, Senderowitz 1999). A study by Mturi (2001) in Lesotho highlights the problem of communications about sex between parents and adolescents The study supports the experiences of participants in my study that parents are either shy to discuss sex related matter or they think the discussion will encourage sexual activities.

Problems with teachers

The attitudes and misbehaviours of teachers and time constraints were indicated as major problems experienced by teenagers. Participants complained about a judgemental attitude among teachers. There were also indications from learners that teachers take advantage of teenagers who seek information by having sex with them and/or proposing sex to them. They questioned whether teachers who will be willing to help have time for them.

Studies indicate that teachers and other professionals are reluctant to provide unmarried or childless young people, especially girls, with sexual knowledge and/or contraceptives (Murray et al., 2000). McCall & McKay (2004) indicate that even in a developed country like Canada the sexual health education to the youth in schools are inadequate

Problems with other teenagers

Among the problems experienced from other teenagers were lack of confidentiality, lack of information and being given misleading information. Participants indicated that other teenagers are unable to keep secrets which leads to lack of trust among them. Other teenagers are also accused of misinforming others and promoting sexual engagements amongst teenagers.

The provision of misleading information among teenagers was also observed by Ajuwon et al. (2006) who indicate that adolescents harbour misconceptions around issues of sexual engagements

7.2.3.2 Suggestions on prevention of risky sexual behaviours

Participants made valuable suggestions on what can be done to prevent sexual risky behaviours among participants. The roles of parents were suggested more around issues of communication. Participants indicated that parents should talk more with their children and take the responsibility of teaching, guiding and intervening in the lives of their children.

Suggestions also encourage teachers to give more information through teaching and giving advices and reaching out to learners.

As far as clinics are concerned, it was suggested that nurses should be more involved through giving good treatment and support, planning and implementing strategies of addressing issues of sexuality among young people and also communicating.

The role of teenagers was identified to be more of taking responsibility of their own lives, communicating with others and getting involved in issues that concern young people.

7.3 Conclusions

This study focused on knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in rural Free State town. The study was largely quantitative and used questionnaire to collect data. Qualitative information was also collected through incorporating open-ended questions

within the questionnaire. Both methods provided valuable information that lead to significant findings as presented above. The objectives of the study and hypothesis are believed to have been addressed adequately and answered. However, it is believed that a comprehensive mix method study could have enhanced the depth of the study. Limitations of the study were outlined in chapter 1.

7.4 Recommendations

The following recommendations are presented based on the findings of this study. The researcher is however aware of the fact that the findings can only be generalized to the population of this study:

- There should be serious concerns about the low knowledge levels of respondents regarding HIV/AIDS. The low levels of knowledge could be an indication that much more work in terms of fact focused education need to be done focusing on what HIV/AIDS is, how it gets transmitted and how it can be prevented. Knowledge base need to be boosted through the provision of proper and adequate information about sex and HIV/AIDS to learners in the school setting, home and other relevant institutions
- Continuous peer education training and involvement of young people in plans to address HIV/AIDS is highly recommended.

Education of adolescents has been acknowledged as a more proper way of targeting HIV/AIDS if we are to win the battle of fighting it. A study by Jaiswal et al. (2005) found that high school students had significant improvements in the knowledge and attitudes after an education programme was offered.

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- This study also calls upon intergenerational communication and information sharing forums. It is recommended that services be linked through involving schools, clinics, churches, parents and teenagers as social support systems to youth. Programmes that facilitate

engagements of these stake holders should be aimed towards building self-esteem of young people and assisting in determining goals for the future. Such programmes could incorporate discussion forums in which the views of participants will be valued and exposure to more information is obtained.

- Young people continue to engage in sexual activities despite the risks associated with it. Youth friendly condom distributing zones should be established as this could further enhance the use of condoms among teenagers

- It is strongly recommended that parents and schools should listen to the voices of children regarding their experiences at clinics. The protection of teenagers' privacy and confidentiality is vital if they are expected to use health care facilities

- School authorities and health care practitioners like community nurses, should meet and discuss ways of helping learners in a respectful way and decide on user friendly way of promoting sexual health.

- School principals and/or life skills teachers should organize meetings to share the outcome of this research with parents in a non-threatening way. Parents should be supported and empowered with information on HIV/AIDS and encouraged to communicate with children about this issue.

- Parents, teachers and nurses should be encouraged to be more accessible and lenient towards young people as their positive attitude could curtail engagements in risky sexual activities. Thus, the study calls for robust engagement of community leaders and elders working together with teenagers in programmes designed to enhance education.

- Education programmes should endeavour to address peer pressure and instil positive role modelling in young people towards their peers. Positive peer pressure has been noted as playing an important role in influencing behaviour change amongst adolescents by theorists who believe that knowledge but environment and social context influence behaviour (Swart et al. 2005).

- In-depth and comprehensive studies using both qualitative and quantitative methods among young people in rural areas are highly recommended.

7.5 Concluding remarks

This study explored knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS using a questionnaire. The study also explored participants' views on the experiences of teenagers when seeking information and their suggestions on prevention of risky sexual behaviours among teenagers (open-ended questions included in the questionnaire). It is fully acknowledged that the study is not a proper quantitative-qualitative combined study; however, the open-ended questions provided valuable and rich data from which important themes were established. Proper use of both designs would be advantageous in future.

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ADDENDUMS

DEPARTMENT OF SOCIAL WORK

Addendum i

GUIDELINES FOR THE PARICIPANT INFORMATION SHEET (PIS).

Date:

Ref: (supervisor's name) and tel
Student researchers:

Dear…

You **are invited to participate** in a research study titled:

The following written information is given to assist you to make a decision whether to participate or not. Please feel to ask the researchers to clarify anything in this letter is not clear to you..

The **goal this** research is ……. . and we hope that the findings of this study will contribute to…….

If you agree to participate you will be r**equired** to make yourself available (for a one-to-one interview / participate in a group discussion/complete a questionnaire) which will take about…. your time. This will be done at a venue……. .

The **potential risk(s)** for participating is/are (that you find some of the questions of a very personal nature (OR INDICATE THAT NO POTENTIAL RISKS ARE FORESEEN.)You are encouraged to discuss with the researcher or assistant any feelings of discomfort that you may experience during or after the interview. We will also make available an independent consultant for this purpose should this be your choice.

Participation in this research is **voluntary.**
You are also free to withdraw from the research should you at any time feel uncomfortable to continue.

There are no financial **costs or direct benefits** for you for by participating the project.. However your participating is highly valued for the potential……..

Every attempt will be made to keep information **confidential/anonymous** in the sense that you will not be named in the writing up of the research. (not applicable in focus groups, alert the participant that partaking in a focus group means that you share information with other in the group and al though the group may agreed to the norm of confidentiality, the researcher cannot guarantee this) The findings of the research will be reported and may be published but no participant's **identity** will be revealed.

If you agree to participate, kindly complete the following and sign.

CONSENT FORM.

Title of research:

I have read the information about this research / it has been read to me. I had the opportunity to ask question an my questions have been answered to my satisfaction.
I……. confirm that I understand the goal, and risks/benefits of participating in this research project.

I was informed that the findings will be reported a**nonymousl**y and that the researcher will at all times adhere to professional ethical behaviour in this project.

(In the case of focus groups, add that group member realise that the researcher cannot guarantee respect for confidentiality by other participants.
I am participating voluntarily and am aware that I can withdraw at any time should I wish to do so.

Signed (participant) name and signature

Date:……

Researcher name and signature

Date:……..

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FACULTY OF COMMUNITY AND HEALTH SCIENCES

Addendum ii

DEPARTMENT OF SOCIAL WORK

TSEBISO YA BA NKAKAROLO Mohla: April 2007

Ref: Supervisor: Professor S. Terblanche Tel: (021) 959 2277
Student researcher: Gladys Klaas-Makolomakwe Tel: 073 137 4618
Student No.: 2615552

Motswadi ya ratehang

Ngwana wa hao o memelwa ho nka karolo patlisisong ya thuto sehlohong se latelang: Tsebo, mokgwa le boitshwaro ba baithuti ba dikolo tsa sekondari mabapi le lefu la HIV/AIDS motse-toropong Foreisitata.

Tlhahiso leseding e latelang e etseditswe ho ka o thusa bakeng sa ho nka qeto hore ngwana wa hao a ka nka karolo kapa thjee. Ka kopo, phutulloha ho ka botsa dipotso ho motsamaisi wa dipatlisiso ha o hloka tlhalosetso efe kappa efe ya lengolo lena.

Dintlhakgolo tsa patlisiso ena ke ho toboketsa tsebo ya ngwana wa hao ka lefu la HIV/AIDS mme re tshepa hore sepheto se tla fumanwa se tla bapala karolo ntshetsopeleng le twantshong ya lefu lena.

Ha o dumela hore ngwana a ka nka karolo, ngwana o tla lebellwa ho nka karolo puisanong ya sehlopha e tla nka hora le ho tlatsa pampiri ya dipotso e tla nka metsotso e mashome a mararo. Tsena tsohle di tla etsetswa sekolong ka mora dihora tsa thuto.

Bothata bo ka hlahang ho nkeng karolo ke hore ngwana a ka fumana tse ding tsa dipotso di le mabapi le bophelo ba hae. Ngwana o kgothalletswa ho bua le motsamaisi wa patlisiso ena kapa bathusi ba hae haeba a na le ho se ikutlwe hantle ka morao kapa lekgatheng la patlisiso. Hape, ngwana o lokolohile ho ka ikgula patlisisong nako efe kapa efe ha a se o sa batle ho tswella. Motho ya ikgethileng ho ka buisana le batho o tla ba teng bakeng sa taba ena ha eba ngwana a ka batla ho bua le motho e mong ya sa nkeng karolo patlisisong.

Ho nka karolo mona ke ka boithaupi feela, ho nka karolo ha ngwana wa hao ho amohelehile haholo bakeng sa patlisiso tabeng ena e re amang le ho ntshetsa pele mekga ya twantsho ya ho thibela lefu lena. Ha ho moputso o hlophisitsweng bakeng sa hae ha a nka karolo projekeng ena.

Teko tsohle di tla etswa hore sepheto se dule se le lekunutu mme a sa tsebahale ka hore a se hlahiswe ha ho ngolwa raporoto ya patlisiso ena. Ho nka karolo puisanong ya sehlopha ho bolela hore o tla arolelana tsebo le ba bang sehlopheng mme le ha eba ho ka dumellanwa ka lekunutu la sehlopha, motsamaisi wa patlisiso a ka se kgone ho ka tiisa sena. Sepheto sa patlisiso ena se tla repotwa mme se ka phatlalatswa entle le ho hlahisa bankakarolo.

Haeba o dumela hore ngwana a ka nka karolo, ka kopo tlatsa foromo e latelang mme o e saene:

FOROMO YA TUMELLO.
Sehloho sa patlisiso: Tsebo, mokgwa le boitshwaro ba baithuti ba dikolo tsa sekondari mabapi le lefu la HIV/AIDS motes-toropong wa Foreisitata.

Nna ke badile tlhahisoleseding ka patlisiso ena/ kapa ke e balletswe. Ke bile le monyetla wa ho botsa dipotso mme tsa arajwa ka ba ka kgotsofala.

Nna……. Ke tiisa hore ke utlwisisa dintlhakgolo le bothata/tefo ha ngwana a nka karolo projekeng ena ya patlisiso.
Ke ile ka tsebiswa hore sepheto se tla phatlalatswa ntle le ho bolela mabitso mme mmatlisisi o tla ikamahanya le bonkgonthe ba setho projekeng ena. Bakeng sa puisano ya sehlopha, ke ellellwa hore mmatlisisi ha a na hona ho ka tiisa hlompho ya lekunutu la sehlopha ke ba bang ba bankakarolo.

Ngwana o tla nka karolo ka boithaupi mme ke elellwa hore a ka ikgula neng kapa neng ha a batla.

Saene:

Monkakarolo: Lebitso le saene	Motswadi: Lebitso le saene
……	……
Mohla:……	Mohla:……

Addendum iii

Topic: Knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in a rural Free State town

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Instructions:

Please read questions carefully

Where the option **other** appear, please write your answer next to the box

Please always make a tick (√) where asked to do so

Please use the pencils provided

Please ask for help when needed

Please note: your information is confidential and will be treated with confidentiality

There is no right or wrong answer for any question

PLEASE IDENTIFY YOURSELF BELOW:

Please make a tick (√) next to your choice:

Male	**Female**

How old are you?	**15**	**16**	**17**	**18**	**Other**

You are in grade	**Grade 9**	**Grade 10**	**Grade 11**	

Your home language is	**Sesotho**	**isiXhosa**	**Setswana**	**Other**	

KNOWLEDGE ABOUT HIV/AIDS

1. Who can get HIV/AIDS?

No.	***Options***	***Please tick (√) one choice per option***		
1.1	Only children can get HIV/AIDS	True	False	Unsure
1.2	Only young people can get HIV/AIDS	True	False	Unsure
1.3	Only adults can get HIV/AIDS	True	False	Unsure

1.4	Anybody can get HIV/AIDS	True	False	Unsure

2. You can be HIV infected by:

No.	***Options***	***Please tick (√) one choice per option***		
2.1	Shaking hands with a HIV+ person	True	False	Unsure
2.2	Sharing eating utensils with a HIV+ person	True	False	Unsure
2.3	Sharing toilet facilities with a HIV+ person	True	False	Unsure
2.4	Eating food prepared by HIV infected people	True	False	Unsure
2.5	Kissing somebody who is infected and has no open sores in the mouth	True	False	Unsure
2.6	Having unprotected sex	True	False	Unsure
2.7	Having blood contact with the blood of an infected person	True	False	Unsure
2.8 Other ways of getting infected with HIV not mentioned above (please write here) …… ……				

3. HIV/AIDS can also be passed on from:

No.	***Options***	***Please tick (√) one choice per option***		
3.1	An infected mother during pregnancy to her unborn baby	True	False	Unsure
3.2	An infected mother to her baby during childbirth	True	False	Unsure
3.3	An infected mother through breastfeeding	True	False	Unsure

4. A healthy looking person can be carrying HIV (Please tick (√) one choice)

True	False	Unsure

5. There is cure for HIV/AIDS (Please tick (√) one choice)

True	False	Unsure

6. You can protect yourself from getting HIV by

No.	***Options***	***Please tick (√) one choice per option***		
6.1	Abstaining from sex	True	False	Unsure
6.2	Using condoms	True	False	Unsure
6.3	Avoiding eating with others	True	False	Unsure
6.4	Not shaking hands	True	False	Unsure
6.5	Avoiding HIV infected blood	True	False	Unsure
6.6	Having sex with a virgin	True	False	Unsure
6.7 What other methods have you heard about that can protect one form getting infected (please write here)				

……..……
……

7. I got information about HIV/AIDS from (please tick (√) all those which are true)

No.			No.			No.		
7.1	Television		7.6	Parent		7.11	Church	
7.2	Radio		7.7	Friend		7.12	Peer group	
7.3	Newspaper		7.8	Other family member		7.13	Community AIDS group	
7.4	Magazines		7.9	School				
7.5	Leaflets		7.10	Clinic				
7.14 Other: ……. ……								

8. Getting information about HIV/AIDS is easy (Please tick (√) one choice)

True	False	Unsure

9. Do you know your HIV/AIDS status? (Please tick (√) one choice)

1.Yes	2.No

10. Do you talk about HIV/AIDS with your partner? (Please tick (√) one choice)

1.Yes	2.No

11. Do you know your partner's HIV/AIDS status? (Please tick (√) one choice)

1.Yes	2.No

12. Do you think your partner is having other sexual relationships? (Please tick (√) one choice)

1.Yes	2.No

ATTITUDE ABOUT HIV/AIDS

13. Do you know someone who told people that he/she has HIV/AIDS? (Please tick (√) one choice)

Yes	**No**
[if this is your choice, please go to question 14]	**[if this is your choice, please go to questions 15]**

14. If yes in Q13, how do you treat him or her? (Please tick (√) your answer)

14.1 I avoid him/her because I am not sure how to treat him/her	
14.2 I accept him/her the same way that I accept other people	
14.3 I avoid him/her because I do not want to be associated with HIV infected / AIDS people	
14.4 I avoid him/her because I am afraid of HIV/AIDS people	

15. If no in Q13, Should you know someone who is HIV/AIDS infected in future, how will you treat him or her? (Please tick (√) your answer)

15.1 I will avoid him/her	
15.2 I will accept him/her the same way that I accept other people	
15.3 I will avoid him/her because I do not want to be associated with HIV infected / AIDS people	
15.4 I will avoid him/her because I am afraid of HIV/AIDS people	

16. Do you think you can be infected by HIV? (Please tick (√) one choice)

Yes	No

17. Do you think one of your family members can be affected by HIV/AIDS? (Please tick (√) one choice)

Yes	No

SEXUAL BEHAVIOUR

18. Have you ever had sex? (Please tick (√) one choice)

Yes	**No**
[if this is your choice, please go to question 19]	**[if this is your choice, please go to questions 31]**

19. If yes in Q18, how old were you when you first had sex? (Please tick (√) one choice)

19.1 Younger than10 years	
19.2 Between 10 and 15 years	
19.3 Older than 15 years	

20. What was the sex of your partner(s)? (Please tick (√) one choice)

Male	Female	Both

21. Do you continue having sex since the first time you had it? (Please tick (√) one choice)

Yes	No

22. if yes in Q21, how often do you have sex? (Please tick (√) one choice)

Once every week	Once every month	As often as needed

23. With how many different partners have you had sex in the last 12 months? (Please tick (√) one choice)

1	2	3	More than 4

24. How long ago did you last have sex? (Please tick (√) one choice)

Past week	A month ago	A year ago

25. The last time you had sex, did you know your partner for more than 7 days? (Please tick (√) one choice)

Yes	No

26. The last time you had sex, did you or your partner use anything to prevent pregnancy or prevent getting infected? (Please tick (√) one choice)

Yes	No

27. If yes in Q26, what did you or your partner use? (Please tick (√) your answer)

27.1 Condom		27.4 Gel or foam	
27.2 Injection		27.5 Withdrawal	
27.3 Pill			

28. What are your reasons of having sex? (tick (√) all those which are true

28.1 Because of natural feelings		28.5 I am forced to do it	
28.2 I get paid for it		28.6 I am experimenting	
28.3 My friends do it		28.7 It is good for the relationship	
28.4 Because adults do it		28.8 My partner wants it	
28.9 Other reasons not mentioned above (please write here) …… ……			

29. How often do you use condoms with your partner(s)? (Please tick (√) one choice)

Never	Seldom	Regularly	Always

30. If you chose never option in Q29, what are the reasons for not using condoms? Please tick (√) one choice)

30.1 I don't have condoms		30.4 A condom does not satisfy me	
30.2 My partner does not want to use condoms		30.5. A condom disturbs when having sex	
30.3 I use other preventions			
30.6 Other reasons not mentioned above (please write here) …… ……			

31. Do you think it is okay for women to say no to sex? (Please tick (√) one choice)

1.Yes	2.No

32. Do you think it is okay for men to say no to sex? (Please tick (√) one choice)

1.Yes	2.No

SOCIAL FACTORS

33. What are the reasons teenagers have sex?
Please tick (√) your choice [1=most important, 2=important, 3=less important]

33.1 Parent(s)/guardian(s) don't talk to them	1	2	3
33.2 Because of using alcohol	1	2	3
33.3 Because of using drugs	1	2	3
33.4 Because their friends are having sex	1	2	3
33.5 No proper information about sex is given	1	2	3
33.6 Because they get money for having sex	1	2	3
33.7 Young girls are advised to have sex	1	2	3
33.8 Young boys are advised to have sex	1	2	3
33.9 They are forced to have sex	1	2	3
33.10 Other reasons (please write here) …… ……			

34. What problems do teenagers face when wanting information or help at clinics?
……
……
…….

35. What problems do teenagers face when wanting information or help from parents?
……
……
…….

36. What problems do teenagers face when wanting information or help from teachers?
……
……
…….

37. What problems do teenagers face when wanting information or help from other teenagers?
……
……
…….

SUGGESTIONS FOR PREVENTION

38. What should be done by parents to prevent risky sexual behaviours among teenagers?
……
……
……

39. What should be done by teachers to prevent risky sexual behaviours among teenagers?

……
……
……

40. What should be done by nurses to prevent risky sexual behaviours among teenagers?

……
……
……

41. What should be done by teenagers to prevent risky sexual behaviours among teenagers?

……
……
……

THANK YOU FOR YOUR TIME **THANK YOU FOR YOUR TIME**